# CONCERNING DEATHS INCUSTODY

WITHIN WASHINGTON'S DEPARTMENT OF CORRECTIONS

DECEMBER 1, 2024

# CONCERNING INCUSTODY DEATHS

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# 2023-2024 CONCERNS RAISED

## DOC HAD ROUTINELY FAILED TO REQUEST AUTOPSIES

### BACKGROUND

**Saturday, June 10, 2023 - UFR 23-008**

Timothy Hemphill commits suicide by hanging at the Washington State Penitentiary (WSP) in the highly monitored BAR Units that house vulnerable individuals with protection and mental health conditions.

**Sunday, June 11, 2023 - UFR 23-007**

Everett Alonge - commits suicide by jumping headfirst from the Tier at the Washington State Penitentiary (WSP) in the highly monitored BAR Units that house vulnerable individuals with protection and mental health conditions.

**Thursday, June 15, 2023 - UFR 23-009**

Michael Giordano - commits suicide by jumping headfirst from the Tier at the Washington State Penitentiary (WSP) in the highly monitored BAR Units that house vulnerable individuals with mental health conditions.

#### FALL/WINTER 2023-2024

Department of Corrections (DOC) staff at multiple level bring forth internally that it appears many individuals who had died in custody during 2023, did not have autopsies listed as being done on their death certificates. A request for an autopsy is required per Department of Corrections (DOC) Policy 600.230 – Death of Incarcerated individuals.

All Department of Corrections (DOC) staff at that point could see a scanned copy of a death certificate in the Department's OnBase system. Making it possible to corroborate that information with the facts of an Unexpected Fatality Review or electronic incident report that most staff can access.

These concerns were pushed to the highest levels of Department of Corrections (DOC), Secretary Cheryl Strange and Deputy Secretary Sean Murphy. After fierce resistance from the prisons administration, a joint memo directing staff to request an autopsy in all circumstances including death in a community hospital was reiterated. Audits were begun at that time by the Sentinel Events Staff reporting directly to Secretary Strange on the status of missed autopsies and any associated processes. The Department of Corrections (DOC) had indeed been failing to systematically ensure that autopsies were being requested and the process documented. The exact number of individuals whose deaths were not properly addressed by policy remains unknown.

*NO AUTOPSIES WERE COMPLETED FOR THE THREE BAR UNIT SUICIDES*

# GROWING CONCERNS

## FIVE CONCERNING INCUSTODY DEATHS OCCUR

Each of the below deaths, individually and collectively speaks to the overall picture that the Department of Corrections (DOC) has a critical lack of integrity and safeguards within internal leadership, process/procedure, and performance management of the agency. This sits squarely with Secretary Cheryl Strange and Deputy Secretary Sean Murphy.

The following report is the product of a larger conversation uniting an alliance of diverse voices within employees, families, incarcerated/supervised individuals, advocacy, and community within the Department of Corrections (DOC), both inside and outside facilities, dispersed through all levels of the agency. The following summary attempts to serve as a collective narrative to bring attention to the systemic concerns that have flourished under the divisive and toxic leadership of Cheryl Strange and Sean Murphy during their time with the Department of Corrections (DOC).

Each day that passes where we continue to ignore their profound lack of leadership, puts our communities, employees, and incarcerated/supervised population at growing odds, decreasing our ability to succeed toward our goals, increasing risk to everyone's safety, and exposing taxpayers to enormous financial liability.

**JANUARY 17, 2024**

Justin Fessel – Coyote Ridge Corrections Center – Medium Security Unit

**FEBRUARY 6, 2024**

Clifton Carey - Washington State Penitentiary – Intensive Management Unit

**MARCH 16, 2024**

William Phouthavongxay - Washington State Penitentiary – West Complex

**APRIL 24, 2024**

Alex Kuhnhausen - Washington State Penitentiary – Intensive Management Unit

**JUNE 23, 2024**

Danielle Reyes - Washington Corrections Center for Women – Close Custody Unit

*The above is not an inclusive list of individuals that died in Department of Corrections (DOC) custody during the referenced period.

# WASHINGTON STATE DEPARTMENT OF CORRECTIONS

STATUS WITH INCUSTODY DEATH REVIEWS

## ESSB 5119 (2021) - UNEXPECTED FATALITY REVIEW

During the 2021, Legislative Session, former Senator Jeannie Darnielle joined by Senators Das, Hasegawa, Mullet, Nguyen, Robinson, Salomon, and Wilson, C. led the effort under ESSB 5119 to create the Unexpected Fatality Review (UFR) process in the wake of numerous high-profile lawsuits over egregious systemic failures that led to the death of incarcerated individuals at the Department of Corrections (DOC). ESSB 5119 amended RCW 72.09.770, adding sections that required the Department of Corrections (DOC) to:

Conduct an Unexpected Fatality Review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds for review.

Convene an Unexpected Fatality Review team and determine the membership of the review team. The team shall be comprised of individuals with appropriate expertise including, but not limited to, individuals whose professional expertise is pertinent to the dynamics of the case. The unexpected fatality review team shall include the Office of the Corrections Ombuds or the ombuds' designee, and a representative from the Department of Health. The Department shall ensure that the unexpected fatality review team is made up of individuals who had no previous involvement in the case.

> *"The primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and* ***strengthen safety and health protections*** *for prisoners in the custody of the department".*

Upon conclusion of an unexpected fatality review required pursuant to this section, the department shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the governor. Reports must be distributed to the appropriate committees of the legislature, and the department shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained. An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public website, except that confidential information may be redacted by the department consistent with the requirements of applicable state and federal laws.

# FINDING ROOT CAUSES

ANALYSIS FAILING

## DEATH 1: JUSTIN FESSEL – 01/17/24 – CRCC

On 01/10/24 - Justin Fessel was transported from the Coyote Ridge Corrections Center to Kadlec Medical Center. Over the next week Mr. Fessel continued to deteriorate and despite intensive medical intervention, he died on 01/17/24. Mr. Fessel's death was immediately classified by the prison as "expected", and only a shift report was ever completed. An autopsy was not requested by Department of Corrections (DOC).

On 01/18/24, the Office of Correction Ombudsman determined the death was "unexpected" and requested a UFR be completed. Mr. Fessel's UFR was completed under 24-002 and published 04/30/24. Chief Medical Officer Dr. MaryAnn Curl and the UFR committee concluded Mr. Fessel's death resulted from respiratory failure secondary to complication of an Influenza B infection and cardiopulmonary arrest. The manner of death being natural.

No corrective action to prevent a similar fatality in the future was recommended. Root Cause Analysis arrived at the need to increase Influenza vaccinations while in custody, and to develop better end of life planning and next of kin notifications. Notably, Mr. Fessel is the brother-in-law of Mrs. Kuhnhausen, the wife Alex Kuhnhausen, noted in Death #4. Mr. Fessel's family contends he tried to seek help on several occasions prior to declaring a medical emergency, and no one would listen to him. At the point Mr. Fessel was having trouble breathing, he declared a medical emergency. Unfortunately, Mr. Fessel, despite intensive hospital interventions, was too sick to be saved and succumbed to his illness in hospital on 01/17/24.

### POLICY CONCERNS:

Department of Corrections (DOC) Policy 620.200 – Death of Incarcerated Individuals requires an autopsy to be requested by the facility superintendent/designee upon the death of an incarcerated individual. An autopsy was not requested in this incident.

Department of Corrections (DOC) Policy 400.110 – Critical Incident Review was revised 07/23/24. As Mr. Fessel's process was concluded prior to the new revision, this would necessitate his review being completed under the prior version of policy in effect from 09/24/20-07/23/24. This policy language requires a CIR be completed when unnatural death or serious bodily injury of an individual under Department jurisdiction, contract staff, volunteer, or visitor occurs on Department premises (e.g., death by suicide of an incarcerated individual).

On 01/17/24 at 03:59 hrs., Lt. Ryan Hanh completed an internal Incident Management Reporting System (IMRS) electronic incident report listing Mr. Fessel's death as "expected". Although initially listed as an "expected" death, on 01/18/24, OCO determined that the circumstances merited a further review under the Unexpected Fatality Review (UFR) process. A CIR was not requested at that time, thus leaving the remaining long history Mr. Fessel had under the Department's jurisdiction largely unexamined, and his UFR resting on a policy violation that left the only information to be the medical record and IMRS record. No fact finding, staff interviews, or systemic reviews were completed to analyze root cause. Mr. Fessel's death remains listed as an "expected" death within the internal incident reporting system.

## DIFFERING ROOT CAUSES OF DEATH

According to the UFR committee report examined the findings of the Mortality Review Committee which reviewed the medical record, the care delivered and provided the following findings:

- A seasonal influenza vaccination may have prevented the incarcerated individual from developing more severe disease and complications.
- Routine immunizations are not emphasized during Department of Corrections (DOC) primary care visits.
- Incarcerated individuals may not be aware of the importance of routine immunizations nor how they can request vaccinations.

## THE MRC COMMITTEE RECOMMENDED:

- Promoting routine vaccinations to educate staff and incarcerated individuals, and
- Including immunizations as part of the Patient Centered Medical Home focus in 2024.

## UFR COMMITTEE REVIEW

Care synopsis: This incarcerated individual had not received an influenza vaccine this season. He was relatively young, otherwise healthy, and was not identified as high risk for complications of influenza. He did not immediately request medical care when he became ill and there is not documentation that shows why he chose not to receive a vaccination. He had not documented his end-of-life care wishes. His family members participated in care planning with hospital team.

Clinicians on the committee discussed that he received appropriate medical treatment from the time of his care request through his death. They agreed that no clinician would expect this outcome. Influenza B infection has a five times higher death rate than Influenza A in those that are unvaccinated. The only variable that may have changed this outcome was receiving a flu vaccination. Members acknowledged that even so, flu vaccines are not 100% effective but have been shown to lessen the severity of the disease.

## VACCINATIONS IN PRISON FACILITIES

Overall vaccine rates in prison are similar to the general population. Influenza vaccines are offered to all incarcerated individuals through vaccine clinics and for individuals identified as high risk, in-person appointments are offered with facility infection prevention nurse. Flu vaccine clinics are promoted through communication sent to incarcerated individuals and flyers are posted throughout the facility including their living units. The committee agreed prioritizing a routine vaccination program for incarcerated individuals will increase acceptance rates and reduce the spread of infectious disease within prison facilities.

Members discussed the historical distrust of medical care offered in prisons and that incarcerated individuals are less likely to report a contagious illness when isolation is required. Department of Corrections (DOC) Health Services wants to have more discussion around decreasing vaccine hesitancy including how to promote preventative vaccinations as routine part of any care visit. Part of the strategy is building relationships and credibility with the incarcerated individuals. The way vaccines are presented is impactful especially with younger otherwise healthy individuals. Members advocated using a multi-pronged, creative approach to positively impact vaccination rates. This may include a peer-to-peer education model, tailoring education materials from DOH and HCA for the incarcerated population and utilizing electronic media opportunities to share the message.

The OCO representative offered to assist with messaging and acknowledges that years of Covid mitigation strategies may have hindered vaccination discussions in the prison facilities.

Department of Corrections (DOC) end-of-life processes: The committee reviewed the Department of Corrections (DOC) process that occurs when an incarcerated individual becomes seriously ill. A Department of Corrections (DOC) Health Services clinical staff member reviews the individual's advanced care planning wishes and notifies custody of the individual's health status. This notification triggers a series of actions including:

Notifying next of kin or emergency contacts identified by the incarcerated individual,

Notifying the facility chaplain, classification counselor, etc.

Providing permission for the community hospital to communicate with next of kin/emergency contact, and

Arranging special communication or visitation. Members requested the seriously ill notification happen earlier in the disease process when the incarcerated individual chooses to involve their next of kin in care planning. Ideally, interdisciplinary discussions happen when an incarcerated individual is diagnosed including coordinating the most appropriate support (which may be the next of kin) and working closely with custody staff to support communication and visitation.

## COMMITTEE FINDING

The MRC committee found that Mr. Fessel died as a result of respiratory failure secondary to complications of Influenza B infection and cardiopulmonary arrest. The manner of death was natural.

## DEATH CERTIFICATE

Reviewing Mr. Fessel's death certificate shows the following causes of death:

Cardiopulmonary Arrest – interval: immediate

Acute Hypoxic Hypercapnic Respiratory Failure, Septic Shock

Severe Acute Respiratory Distress Syndrome

Influenza B, Necrotizing Pneumonia with MRSA.

**Other condition contributing to death: Inhalation Drug Use**

## MRC COMMITTEE VS UNEXPECTED FATALITY REVIEW

The interpretation of cause of death determined by the Mortality Review Committee failed to examine the full sequence of causes of death, and the contributing factor of inhalation drug use that was listed on Mr. Fessel's death certificate. In the absence of a Critical Incident Review, other information available to staff via internal systems including Mr. Fessel's three decades of polysubstance abuse, 8 prior drug convictions, and his nearly continuous time under the Departments jurisdiction in prison or on supervision (1997 – present), to include three prior admissions to prison.

There was no exploration of why Mr. Fessel had not been assigned to any programming or interventions since his arrival at Coyote Ridge in October 2023. In the prison environment, there is a constant struggle with high rates of illicit drugs and drug related contraband. With no programming assignments, current conditions regarding drugs, and Mr. Fessel's history with substance use, the addition of "Inhalation Drug Use" should have driven a further conversation.

## ROOT CAUSE ANALYSIS FOR LISTED CAUSES OF DEATH

By addressing these factors, the RCA can identify critical system failures that contributed to the patient's death and help implement corrective actions to prevent future occurrences in the correctional setting.

Mr. Fessel, however, benefited from no true analysis of the root causes of his death. While he may have truly been a casualty of Influenza, benefiting from a Flu Shot, what factors lead to his death including the timeline of any possible custody events prior to his medical emergency, potential complications of the two teeth he had extracted on 01/05/24, and why his death certificate lists "Inhalation Drug Use" remains unclear.

Mr. Fessel's medical records also from the MRC and UFR. His hospital records note, Fessel is a 45-year-old male with unknown chronic medical conditions (Episodes of SVT per chart review from (2018), and mild obesity. Also noted is that Fessel is incarcerated at the Coyote Ridge Corrections Center (CRCC) with **multiple sick contacts**. However, no other sick contacts were noted in his reviews. In Fessel's Goals and Plans of care signed by Dr. Braghadheeswar Thygarajan, MD on 01/14/24, it is noted: "Daughter informed patient used to snort meth and cocaine in the past. It is possible patient snorted other drugs or chemicals in the prisons which could have caused this. It's likely he has severe lung damage from these drugs and chemicals". Although a frontline provider survey was conducted for Fessel as part of his Mortality Review, the provider at CRCC was contacted and no records were noted of a follow up survey with Dr. Thygarajan.

As this case indicates it is often a systemic failure and not simply a medical one that often results in the death of incarcerated individuals. Without the completion of a formal Critical Incident Review by the applicable staff housed within the Men's Prison Division, a true root cause alongside the medical events cannot be evaluated, to determine what truly transpired.

# QUESTIONABLE DEATHS

## AUTOPSY: THE INSIDE AND THE OUTSIDE TELL DIFFERENT STORIES

### DEATH 2: CLIFTON CAREY – 02/06/24 – WSP IMU N

On 02/06/24, Clifton Carey was found unresponsive in his cell in the Intensive Management Unit (IMU) at the Washington State Penitentiary. CPR was initiated and emergency services activated. EMS responded shortly thereafter and made the determination to call time of death. An autopsy was requested, and initial exam and toxicology were both completed by 02/22/24. Despite this, the Autopsy Report was not signed and released to Department of Corrections (DOC) Investigation staff at the Washington State Penitentiary until 04/22/24.

#### AUTOPSY REPORT CC 02-06-0024

Dr. Sally Aiken was contracted by Walla Walla County to complete this autopsy. Her reports summarizes: This 43-year-old male was found unresponsive in his locked cell at lunchtime and had no cellmate. He was last seen at breakfast. Resuscitation was attempted including a cricothyrotomy which, when dissected at autopsy, did not actually enter the trachea. However, this was not associated with significant internal bleeding, and rib fractures from cardiopulmonary resuscitation also had little associated hemorrhage, indicating that these were resuscitative efforts postmortem. First responders described the jaw as having trismus, this was likely rigidity of the jaw that developed after death.

He was asystolic, when discovered. He had a clenched jaw and because he could not be intubated, responders performed a cricothyrotomy for airway access. He was pronounced dead on scene. Subsequent to initial reporting of the case, information was provided that the decedent was HIV-positive, disease status unknown.

The death is attributed to Dilated Cardiomyopathy. Dilated Cardiomyopathy can lead to death via cardiac dysrhythmia.

Clothing and personal Items accompanying the body:

- Much of the clothing and bedding on and with the body is **soiled with blood.**
- Found overlying the body are multiple white towels, and two fleece blankets. One of the fleece blankets is orange and one is gray, and both are **heavily soiled.**
- Found loosely wrapped over the body is a sheet, primarily over the chest area and **heavily soiled with blood.**
- Over the left arm is a towel that is **heavily soiled with blood.**
- An additional orange blanket is found along the left side of the body and is fleece and there are also additional towels, all of **which are blood soiled.**

The body is that of a slightly obese white male whose general appearance is consistent with his age recorded as 43 years. The body is well-preserved and has not been embalmed. It is cold to the touch and has been refrigerated. Rigidity is marked and symmetrical in the upper and lower extremities, and the jaw is clenched. Lividity is dorsal, light purple, confluent, and fixed.

## CORONER GREENWOOD'S REPORT

An inquiry into the death of CLIFTON CHARLES CAREY, a 43-year-old Caucasian male, incarcerated at the Washington State Penitentiary, was conducted by the Walla Walla County Coroner's Office. This inquiry included documentation and investigation of the circumstances surrounding the death. It also included scene investigation, interviews with Department of Corrections (DOC) staff, review of medic's run sheets, medical records, imaging, toxicology, autopsy and histology.

## TIME AND PLACE OF DEATH

The decedent was pronounced dead by Walla Walla Fire Dept. Medics at 1147 hours on Feb 6, 2024, at the Washington State Penitentiary, 1313 North 13th Ave, Walla Walla, WA. He was not transported.

Agencies Involved: Walla Walla Fire Dept. and Washington State Department of Corrections (DOC) Investigations.

**Please Note: For whatever reason the Walla Walla Police Dept. was not notified of the death.**

## CORONERS SUMMARY OF CIRCUMSTANCES

Arrived to gate #3 and escorted to IMU North. Department of Corrections (DOC) staff lead me to cell B7 on the second tier where the decedent was located just outside his cell. He was found covered with a blanket with a large pool of blood around his head apparently from a tracheotomy that was performed during resuscitation efforts. Very chaotic scene with Department of Corrections (DOC) staff wanting to clear the decedent from the cell block quickly, although it was in lock down.

The decedent was laying on the floor of the tier in front of his cell with what appears to be a tracheotomy with gauze in wound. No other signs of injury or trauma. Rigor early and manipulates easily. Lividity present and positionally correct for the position decedent was found in at my time of arrival and blanches easily. The cell was disorganized. Department of Corrections (DOC) staff had been attempting CPR in the cell. It wasn't until medics arrived that he was moved out of his cell.

The call originated at approximately 1115 hours when Department of Corrections (DOC) staff noted he did not roll out for lunch. They discovered him in his bunk with sleeping mask on over his eyes and ear plugs in ears. He was moved to floor and CPR started which included several rounds of Narcan.

Department of Corrections (DOC) staff stated that the decedent was last known alive at breakfast. Department of Corrections (DOC) staff stated to medics that he was down for maybe 30 minutes however, it appears that he was deceased longer than reported. The decedent's history is significant for drug and alcohol abuse, arrhythmia, bi-polar disorder, Toxicology is negative for drugs of abuse.

Coroners Cause of Death

OPINION: Cause of death is Dilated Cardiomyopathy

MANNER OF DEATH: **Due to circumstances known at this time,** manner of death is Natural.

Richard Greenwood Coroner, Walla Walla County

## CRITICAL INCIDENT REVIEW

Initial response time: 11:13:15 (listed as actual time) vs 11:07 PM (Video Time).

The initial timeline of events provided in the CIR includes the following disclaimer: There is a 6-minute discrepancy between the time of the video recording and actual time. The logbooks note the actual time, however, much of the documentation including IMRS, incident reports from custody/IMU staff, and checklists refer to the video times. It appears the IMU staff utilized the video time in the reports and checklists while medical staff utilized the actual time called. Copy of timeline provided in CIR:

| Actual Time | Event | Video Time |
|---|---|---|
| 11:13:15 | Initial Response to cell MB07 | 11:07:15 |
| 11:13:31 | Responding custody Staff enter cell | 11:07:31 |
| 11:14:14 | Unit Nurse enters cell | 11:08:14 |
| 11:14:55 | Staff arrive with AED | 11:08:55 |
| 11:17:50 | Responding nurse arrives with red beg | 11:11:50 |
| 11:19:30 | 3rd Responding Medical Staff Member | 11:13:30 |
| 11:20:33 | 4th Responding Medical Staff Member | 11:14:33 |
| 11:22:25 | 5th Responding Medical Staff Member | 11:16:25 |
| 11:26:40 | EMS Arrives at Cell Front | 11:20:40 |
| 11:27:30 | I/I placed on tier at the direction of EMS | 11:21:30 |
| 11:30:40 | Transport officer on standby in B Mod | 11:24:40 |
| 11:36:00 | Life saving measures continue | 11:30:00 |
| 11:47:00 | Time of death called by EMS | 11:41:00 |
| 11:47:36 | Life saving measures cease | 11:41:36 |
| 11:48:15 | EMS Securing their medical equipment00 | 11:42:15 |
| 11:49:40 | I/I covered with blankets | 11:43:40 |
| 11:50:00 | Cell windows on upper tier covered by staff | 11:44:00 |
| 11:50:00 | IIU on scene | 11:44:00 |
| 11:51:00 | Facility medical and support staff exit mod. | 11:45:00 |
| 11:54:00 | EMS personnel exit mod | 11:47:00 |
| 11:57:00 | Duty Officer notified | 11:51:00 |
| 12:40:00 | CISM on scene | 12:34:00 |
| 13:06:00 | Coroner's office was called | 13:00:00 |
| 13:39:00 | Coroner's office onsite | 13:33:00 |
| 13:47:00 | Next of Kin notification request made to Chaplains. | |

## EMERGENCY RESPONSE

On 02/06/24, CO's Eduardo Michel and Ruben Ornelas was serving lunch in IMU N. Ornelas stated him and his partner found Carey while feeding lunch. Both stated they found him nonresponsive while they were at cell front and attempted to wake Carey. Neither describe how they attempted to wake Carey. Ornelas initiated radio traffic for un unresponsive individual. Sgt. Wise arrived shortly thereafter with a shield, and entry was made with CO's Michel, Ornelas, Siller, and Haven's, with CO Owens remaining outside the cell. Due to the quickness of the response, Sgt. Wise failed to direct anyone to video tape the event as required by policy.

Later CUS Adams did state in her report that there were too many staff involved, and that extra staff were in unit for a planned use of force. Generally, a planned use of force would also be videotaped, however it is not clarified what happened with that effort or if those staff could have come over to participate in this entry.

## CELL ENTRY

Sgt. Wise reported they entered the cell and placed Carey in restrains. He checked for a pulse and did not find one. They moved him to the floor and when nursing arrived, they had an AED. CO Siller stated nursing was on scene right after entry and initiated CPR. CO Michel stated he was third in the cell, got on Carey's back, then immediately restrained Carey. Michel added when they realized Carey had no pulse and was not breathing, they then rolled him over and moved the restrains to the front to initiate CPR. Michel was holding the cuff retainer while CPR was performed. Ornelas stated the nurse-initiated CPR and a call for Narcan was made almost immediately. Ornelas believed that EMS pulled Carey out onto the Tier so they would have more room to work. CO Havens stated he went with the entry team and assisted with placing Carey on the ground. Havens then went outside and waited for the ambulance.

Leanne Davina, LPN reported she was the first nurse responding to the medical emergency. Her statement reads, patient was lying prone on the bed with an eye mask and ear plugs in. Custody had a shield on him and was in restraints at the ankles and hands behind his back. No CPR was being done at this time. I asked for more help to move the patient onto the floor and 6 custody officers assisted. They had to move his restraints from his back to front.

CC3 Coers responded to the cell when he heard the call but stated he saw there was enough staff on scene, he waited till needed to fill a hole. Coers brought the second AED to the scene and gave it to another officer.

## INVESTIGATION

IIU Investigator Hunter stated she heard the radio traffic and the need for paramedics and decided to go to the unit to see what was happening. In the Critical Incident Review report, she recalled arriving to the unit before EMS leaving.

The IMRS electronic incident report completed on 02/06/24 at 14:34 hrs. by CUS Adams states: IIU on scene at 11:50. Crime scene cleared at 12:00. Coroner's office called at 13:06 hrs. and arrived at the facility at 13:39 hrs. Coroner departed the facility at 13:56 hrs.

The Critical Incident Review completed 03/29/24 and signed by Melissa Moore, Team Lead, and James Key, Assistant Secretary/designee for Prisons states Sgt. Todd Wise reported that "a crime scene was not established due to not being a designated crime scene", and "due to the quickness of the incident no one was directed to get a video camera" prior to the cell entry.

Later Custody Unit Supervisor (CUS) Ann Adams stated a crime scene log was not initiated because IIU was on the scene. WSP Investigator Rachel Hunter stated, "a crime scene log was not completed due to her being on scene prior to EMS leaving" and that later, "there was a discussion on the importance of completing the crime scene log anyway".

> *"ONE ISSUE SHE (HUNTER) ENCOUNTERED WAS THE RUSH TO RESUME NORMAL. SHE HAD CUSTODY AND MEDICAL STAFF ATTEMPTING TO CLEAN UP PRIOR TO BEING ABLE TO TAKE PICTURES AND PROCESS THE WHOLE SCENE".*

Coroner Greenwood also stated, "Very chaotic scene with Department of Corrections (DOC) staff wanting to clear the decedent from the cell block quickly, although it was in lock down."

Coroner Greenwood makes a very clear observation that the Walla Walla police Department was not notified of the death. As there were no indications of cause of death, Clifton Carrie's death should have warranted that agency generating an investigation as well.

## SCENE PRESENTATION

Department of Corrections (DOC)'s scene descriptions notably differ from that of Coroner Greenwood and Pathologist Aiken's, regarding the amount of blood involved. Pathologist Aiken noted copious amounts of blood on Mr. Carey's neck and upper chest, as well as heavy soiling of linens including a towel, sheet and blanket. While Coroner Greenwood states in his summary that Carey was found, "covered with a blanket with a large pool of blood around his head apparently from a tracheotomy that was performed during resuscitation efforts."

THROUGHOUT Department of Corrections (DOC)'s 10-PAGE CRITICAL INCIDENT REPORT ONLY 2 REFERENCES TO BLOOD ARE MADE:

Jon Coers, Classification Counselor 3 (CC3) - "after they moved the body, he helped cover up the blood with a towel."

Suzanne Sullivan, Corrections/Custody Officer 2 (CO 2) – "After I/I Carey was removed from the unit, she had another I/I clean up the blood that was left on the tier."

## DEATH SCENE DOCUMENTATION

No clarification between the discrepant information of the autopsy report and staff interviews is noted in the CIR. Nor is there any clarification on whether it was Department of Corrections (DOC) or EMS staff attempted the failed cricothyrotomy procedure. Numerous descriptive statements about roles and duties are described, such as, who retrieved which supplies, who did CPR, who held the IV bag, etc.

However, no mention was made of who attempted the cricothyrotomy, and what sequence of events proceeded or followed to include when or how Mr. Carey began to and continued to bleed.

## CRICOTHYROTOMY

Cricothyrotomy is typically associated with minimal bleeding, primarily due to the avascular nature of the cricothyroid membrane. However, complications can arise, including bleeding from small blood vessels in the surrounding area.

In most cases, the volume of blood loss during a cricothyrotomy is limited, often estimated to be around 10-20 ml or roughly 1-2 tablespoons. Severe hemorrhage is rare but can occur, particularly if a clinician inadvertently damages the superior thyroid artery or other nearby vessels. Proper technique, such as making a vertical incision over the cricothyroid membrane and avoiding lateral extensions, can help minimize the risk of significant bleeding. If Mr. Carey had survived with the failed cricothyrotomy, it would be essential to know if liability for poor outcomes of the procedure belonged to local EMS or Department of Corrections (DOC).

## DEPARTMENT OF CORRECTIONS (DOC) POLICY 320.255 – RESTRICTIVE HOUSING & TIMELINE

Custody staff assigned to a restrictive housing unit will complete cell checks on an irregular schedule, no more than 30 minutes apart, to personally observe individuals in Restrictive Housing. Individuals who are violent or mentally disordered, or who demonstrate unusual or bizarre behavior will receive more frequent observation. All cell checks will be documented in the unit log.

According to the CIR, "Most tier checks were conducted in accordance with Department of Corrections (DOC) 320.255 Restrictive Housing. However, some were outside the timeframes and did not encompass every cell in IMU N. Tier checks for this specific cell were conducted on 2nd shift as follows: 06:19, 06:42, 06:58, 07:29, 09:14, 09:57, 10:24, and 11:10. Thus spacing the Tier checks out in intervals as follows: 23 mins, 16 mins, 32 mins, 1hr 45 mins, 43 mins, 27 mins, and 46 mins."

According to the statements Department of Corrections (DOC) staff made to medics that Coroner Greenwood quoted: "Department of Corrections (DOC) staff believed Mr. Carey had been down for 30 minutes, however, it appeared he was deceased longer than reported."

If Mr. Carey had been down for more than 30 minutes it would seem questionable his body would bleed significantly during a cricothyrotomy, even a failed one. The medical examiners statement notes Mr. Carey's EKG showed asystole (no heart activity or electrical activity) and chest compressions were ongoing.

## BLOOD LOSS

The amount of bleeding that would occur if Mr. Carey were cut (for example, during a cricothyrotomy or another procedure) WOULD LIKELY BE MINIMAL POSTMORTEM for the following reasons:

**No Active Circulation:** In asystole, the heart is no longer pumping blood, meaning there is no normal circulation. Without the heart pushing blood through the vessels, significant bleeding would not occur. Even if there are chest compressions, the circulation generated by CPR is much less than that produced by a functioning heart.

**Chest Compressions and Temporary Circulations:** Chest compressions during CPR do create some artificial circulation, which might cause small amounts of blood to ooze from a wound or cut. However, this circulation is not as strong as that of a beating heart, so any bleeding would be limited. The blood loss would not be as significant as in a patient with normal heart activity.

**Low Blood Pressure:** Even with CPR, the blood pressure generated is significantly lower than normal. This further reduces the likelihood of significant bleeding from a cut.

**Coagulation after Aystole:** After a person becomes a systolic, the blood begins to pool and clot in various parts of the body. This natural clotting response can further limit bleeding if the patient is cut or injured. At the point of asystole with ongoing chest compressions, a cut would cause minimal bleeding. The artificial circulation from CPR might produce some slight oozing, but there would not be significant or active bleeding due to the lack of heart-generated circulation and the onset of blood clotting.

## BLOOD BORNE PATHOGENS

Both the Pathologist and Coroner's reports state that it was reported that Mr. Carey was HIV positive. Neither Mr. Carey's immediate records, his subsequently Department of Corrections (DOC) mortality review, or the CIR note him as being HIV positive in his health record.

Reviewing the photos taken at the scene, no blood is present on what can be seen of Mr. Carey's neatly made bed, but very obviously he is surrounded by a pool of blood on the ground, and blood is covering his neck and upper chest.

While standard practice always reinforces practicing universal precautions, Department of Corrections (DOC) Policy 890.600 – Blood borne Pathogen Protection and Exposure Response requires: "If there has been an occupational exposure to blood or body fluids, any employee, contract staff, or volunteer must be provided a post-exposure follow-up."

With this policy requirement, it would have been especially pertinent to properly document all staff exposure or lack thereof from blood at the scene.

### AUTOPSY ATTENDANCE

Rachel Hunter the facility IIU investigator attended Mr. Carey's autopsy. Investigator Hunter's presence at the Autopsy would not be standard practice or the policy of the Department. Department of Corrections (DOC) Policy 620.200 – Death of Incarcerated Individuals specifically states a department health care practitioner should attend the autopsy whenever possible.

Rachel Hunter is an Intelligence Unit Investigator not a health care practitioner. Investigator Hunter was also present at the event, and notably had her own procedural deficiencies noted in the CIR to include not establishing a crime scene log, and not putting the required photo backers on the evidentiary pictures taken at the scene. Potentially creating optics of a conflict of interest, that would have made the attendance of a different staff more appropriate.

### DR. SALLY AIKEN

Press reports regarding Dr. Aiken are well circulated in Washington State Media. Dr. Aiken served for many years as the Spokane County Medical Examiner. She was investigated by the Medical Commission and Department of Health (2015-2017), after 14 families disputed Dr. Aikens autopsy findings. Ultimately Dr. Aiken was found to have met the medical standard ending the investigation against her. However, since being replaced several of her questionable ruling have been overturned by her replacement Current Spokane Medical Examiner, Dr. Singh.

## CONCERNS RAISED TO DOC, OCO, AND GOVERNOR'S OFFICE REGARDING AUTOPSY'S AND UFR DELAYS

On 04/05/24, Secretary Strange completed a request for extension for UFR 23-003 and mentioned she would be doing the same the following week for 23-004 (Mr. Carey's CIR).

Secretary Strange notes in her email exchange to Kathryn Leathers, Robert Duff, Barbara Serrano, Caitlin Robertson, and Sean Murphy: "The additional burden on coroners to do an autopsy on all deaths in Department of Corrections (DOC) custody is becoming increasingly problematic and something we will need to address in the future."

Caitlyn Robertson with the OCO responded cautioning against any revision that required less autopsies and adding Autopsy's had previously provided collateral information that established cause of death when it was believed to be other than suspected. It is unknown why Mr. Carey's autopsy was even delayed from 02/22/24-04/26/24. All results were available but just not summarized in the official report.

Mr. Carey's final report was delivered to the same investigation's unit at WSP after its completion on 04/24/24, before being forwarded to the Sentinel Events staff who complete document procurement and tracking.

# CONCERNS WERE RAISED

SECRETARY OF DEPARTMENT OF CORRECTIONS (DOC), GOVERNOR'S OFFICE, ATTORNEY GENERAL'S OFFICE AND A LEGISLATOR HAD ALL BE NOTIFIED

## CONCERNS WITH THE WSP IMU

On 03/11/24, family member and former Department of Corrections (DOC) Statewide Family Council Co-Chair, Loren Taylor emailed Barbara Serrano, Governor Inslee's policy advisor on Public Safety, and cc'd Kathryn Leathers – General Council Gov's Office, Robert Duff – Executive Director of Policy Gov's Office, Tim Lang with the Attorney General's Office over Corrections, Department of Corrections (DOC) Secretary Cheryl Strange, Caitlyn Robinson - OCO Director, and Senator Claire Wilson, Chair of the Senate Human Service Committee.

Ms. Taylor had been attempting to bring to light the fear she had for her loved one not being protected by unit staff, and then requesting a safe placement when he felt physically in danger. However, instead of being placed elsewhere he was housed in the IMU and was being refused medical care. Ms. Taylor has been fighting a battle with Department of Corrections (DOC) since 2011, to get verified errors in her loved one's record removed. The Department has acknowledged this information has continued to be leaked by staff to the incarcerated population. Resulting in Ms. Taylor's loved one being routinely targeted while in confinement.

In Ms. Taylor's email she noted one of her concerns was that her loved one while in Walla Walla's IMU, the day prior, had suffered a panic attack, and the custody staff refused him medical care and told him to go to sleep. Ms. Taylor goes on to state, "What is even more distressing is that this very IMU unit had an individual commit suicide in January, and they still continue the cruel and inhumane treatment of individuals". Ms. Taylor reported after this that her understanding of what had occurred with the individual in January (Mr. Carey), from what individuals in his unit were aware, was he had started a fight purposely to go to IMU. When transferred to the IMU he smuggled in a large amount of OTC acetaminophen with the express purpose of committing suicide. Tylenol was not tested for in his autopsy, but the condition of his heart especially considering his underlying health conditions could have certainly been impacted by such drug toxicity.

Ms. Taylor recaps that she had attempted unsuccessfully to resolve this matter with Deputy Secretary Sean Murphy, Assistant Secretary Mac Pevey, Assistant Attorney General Tim Lang, and CUS Ann Adams. Ms. Taylor pleads that her loved one does not deserve to suffer physical harm because of a Department of Corrections (DOC) error, and he does not deserve to be punished consistently when he tries to ask for help to protect himself from the consequences of this error. Ms. Taylor concludes "We are out of options, and I am therefore pleading for assistance in this matter".

Both Secretary Strange and Barbara Serrano replied on 03/11/24. Secretary Strange updated the entire string of recipients that she has asked the Men's Prison Division to investigate the issues described in the email. Barbara Serrano replied that she would await a review from Secretary Strange.

On 03/19/24, Ms. Taylor's loved one was transferred to the Airway Heights Corrections Center near Spokane, and no further communication is noted regarding the original inquiry.

# FORESEEABLE DANGERS

LEVERAGING PROTECTIVE CUSTODY IN VULNERABLE POPULATIONS

## DEATH 3: WILLIAM PHOUTHAVONGXAY – 03/16/24 – WSP W COMPLEX

On 02/20/24, Mr. Phouthavongxay was transferred to the Washington State Penitentiary after numerous infractions for not abiding by prior sanctions at the Airway Heights Corrections Center (AHCC) of cell confinement by eating and showering at the incorrect times. Phouthavongxay was found during the Unexpected Fatality Review (UFR) process as being diagnosed with autism spectrum disorder with attention deficit hyperactivity disorder. Neuro-psychological testing documented an approximate IQ of 81. There is not a clear commentary to what extent Phouthavongxay's cognitive disorders may have been a contributor to his above infractions. It was found that Phouthavongxay was coded correctly in DOC's electronic system for developmental disability support needs based on his current criteria. Phouthavongxay UFR did not note that he had also previously suffered an industrial accident that amputated the lower half of his left leg and required he utilize a prosthetic leg to walk. In totality, it appears the combination of neurocognitive disorders and a sex offense conviction would make Phouthavongxay extremely vulnerable in any carceral setting.

On 02/20/24, upon his arrival the record reads multiple ways whether CUS Brewer identified the risk to Phouthavongxay, or if Phouthavongxay himself knew and was clear to state he felt his safety would be in danger at any of the close custody units of the West Complex of the institution.

Between 02/20/24 and 03/14/24, staff responsible for the Administrative Segregation Review Process offered to screen Phouthavongxay for a referral to the BAR Units which provide protective custody and residential treatment services to eligible individuals. It's unclear to what extent Phouthavongxay understood what was needed or required of him to have this screening completed.

On 03/14/24, after several weeks of not provided a statement identifying why he felt at risk in the West Complex, Phouthavongxay was released to the West Complex. It was not confirmed within the CIR if he was ever actually referred to the BAR units. Several staff did note they believed he was and that his being at the West Complex pending a screening would not be standard procedure. The Critical Incident Review (CIR) report also noted that Phouthavongxay was asked several times between 03/14 and 03/16, if he was sure he was okay being in the West Complex, to which he apparently replied he was. Again, to what extent Phouthavongxay may have understood the social and political climate of a high custody security setting housing primarily security threat group involved individuals is a concerning question.

On 03/16/24 at approximately 2044 hours as Washington State Penitentiary (WSP) officers were securing the West Complex Yard #1 for the evening, when incarcerated individual Johnny Ngo approached the entrance/exit from the Northwest Corner of the yard to return to Echo Unit. Officers noticed that he had a large amount of blood covering this clothing and hands, they placed him into restraints and escorted him to the West Complex Shift holding cell.

After clearing Ngo from the area, Officer noticed what they originally thought was a coat left at the Northeast corner of the yard next to the volleyball court.

As they approached the object, they realized it was an incarcerated individual later identified as Phouthavongxay. They immediately radioed for medical assistance, which was delayed due to the ongoing operability of the radios.

After an additional attempt, a phased response was sent to Yard #1. Officers began life saving measures by rolling Phouthavongxay into the recovery position on his right side to facilitate removal of fluids built up in his mouth/airway. Upon WSP medical staff arriving and assessing Phouthavongxay, they requested an ambulance directly to Yard #1. The ambulance took Phouthavongxay to Saint Mary's Medical Center (SMMC) who then determined that Phouthavongxay would need to be sent by life flighted to Kadlec Medical Center for specialized medical treatment due to the injuries sustained during the assault. Phouthavongxay remained at Kadlec Medial Center receiving treatment until he succumbed to his injuries and died on 03/23/24 at approximately 14:30 hours.

Phouthavongxay's CIR Report presents a succinct summary of the incident and recommendations for moving forward in an action plan. There are considerable failures that for 10 years lighting would be so inadequate in the corner of the large Yard #1, adjacent to some of the most violent units in the state, that individuals in that corner of the yard could not be seen from the yard's entrance during darkness.

In addition to failing to prioritize this critical item, 6-7 cameras in Yard #1 were not functioning and 3-4 of those point to the Northeast corner of Yard #1. The radio system was only operating on 2 of 3 transmitters the week prior. This caused communication gaps that were enough that some staff felt the institution should be on restricted movement.

After an additional attempt, a phased response was sent to Yard #1. Officers began life saving measures by rolling Phouthavongxay into the recovery position on his right side to facilitate removal of fluids built up in his mouth/airway. Upon WSP medical staff arriving and assessing Phouthavongxay, they requested an ambulance directly to Yard #1. The ambulance took Phouthavongxay to Saint Mary's Medical Center (SMMC) who then determined that Phouthavongxay would need to be sent by life flighted to Kadlec Medical Center for specialized medical treatment due to the injuries sustained during the assault. Phouthavongxay remained at Kadlec Medial Center receiving treatment until he succumbed to his injuries and died on 03/23/24 at approximately 14:30 hours.

The statement's made as Johnny Ngo is contacted and placed in restraints also cause pause and the need for additional questions. As he was approaching unit staff, one of the Yard Offer's spoke to the other and directed him to go get his boy (referring to taking Ngo into custody). As Ngo was being transported to a holding cell, he was nearly belligerent with staff and made statements that it was their fault what happened, and they could have stopped it. Numerous officers noted that they had been given verbal instructions to not walk the yard during yard hours on 3rd shift due to staff safety concerns. This was clarified later to have been a misinterpretation of the actual instruction, which was to have adequate people present before walking the yard.

## VULNERABLE INDIVIDUALS

Sex offenders incarcerated in prisons face a heightened risk of violence, including homicide, compared to other individuals. While comprehensive national statistics on the homicide rates of sex offenders in prison are limited, available data from specific states provide some insight into this issue. For instance, in California, sex offenders constitute approximately 15% of the male prison population. However, they accounted for about one-third of the 78 individual homicides that occurred between 2007 and 2015. This disproportionate representation underscores the increased vulnerability of sex offenders to lethal violence within the prison system.

The elevated risk is often attributed to the stigma associated with sex offenses, leading to targeted violence by other individuals. This environment necessitates enhanced protective measures and monitoring to safeguard vulnerable populations within correctional facilities.

While specific statistics for Washington State are not readily available, it is reasonable to infer that similar dynamics may exist, given the broader trends observed in correctional institutions across the United States. Addressing this issue requires concerted efforts to implement policies that protect all individuals, regardless of their offenses, to ensure safety and uphold human rights within the prison system.  In terms of an extra vulnerable individual with neurocognitive disabilities, physical disabilities, and convictions that both he and staff stated would be problematic if he were housed in the West Complex, it is a baffling decision that experienced IMU staff decided involved would have deemed this housing assignment appropriate no matter what Phouthavongxay voiced.

## DEATH 4: ALEX KUHNHAUSEN - 04/24/24 – WSP IMU N

### KATIE'S PLEA FOR HELP

On Monday, April 22nd, 2024, at 7:33 PM, Alex Kuhnhausen's wife Katie sent the following email with the subject line "HELP ME!!! HELP ME!!!" to WSP Superintendent Robert Jackson and then the Department of Corrections (DOC) Correspondence box where it was quickly put into circulation with the Department of Corrections (DOC) Executive Leadership.

Katie Kuhnhausen wrote I am writing to you concerning the medical neglect of my husband Alex Kuhnhausen #401534. My husband is currently being held at the Washington State Penitentiary. Alex was set to be released on April 12th, 2024. Alex received an infraction and signed a document that he felt made sense to sign based on the information provided to him. Alex had been very sick prior to signing this document, supposedly releasing him of needing to attend his hearing on April 15th, because in his mind he would be out of custody, and he wouldn't be there to attend anyway. He was not told that by signing that document they would then go have the hearing that same afternoon, find him guilty and give him 85 additional days. My husband was then moved to IMU North for what was supposed to be an overnight stay until a different housing unit was available. I last spoke to my husband on Saturday, April 13th. I know my husband and if he has to get up at 6am to make a phone call to me, he will do it!

On the day he was supposed to be released I was taking him directly to the Walla Walla ER because the Penitentiary had not medically met his needs. He needed to get medical attention fast. I have called the Penitentiary over the last week 16 times trying to get help and/or answers about my husband. I left messages for Counselor Coors and Anne Adams asking for them to do a welfare check on my husband because something wasn't right. I spoke to an officer Lomeli on Friday where he assured me that he would tell Anne Adams to do the welfare check on my husband. I scheduled a visit for Sunday, April 21st because I still hadn't heard from my husband, and nobody had returned my phone calls. I made the four-hour drive from Vancouver to Walla Walla expecting to see Alex. I waited for my husband to be brought in from IMU, but he never came. I was informed by an officer and a mental health person that my husband was not able to come to the visit because he physically couldn't make it. They had found him almost incoherent and severely dehydrated! Not one person took me seriously when I said my husband was sick and I wanted them to do a welfare check on him!

Today, Monday, April 22nd I left a message for Counselor Coors and for Scott Buttess the manager of mental health and medical still have yet to have someone return my calls. My husband has been medically neglected by the Penitentiary and I want answers! I have called and left messages today to find out about my husband's condition and nobody has returned my calls. They opted to keep him at the prison hospital, not allowing him to get real medical care. That decision is absolutely unacceptable!

I had to leave the Penitentiary and make the four-hour drive home not knowing anything other than my husband has been medically neglected and I had been ignored. My brother-in-law (Justin Fessel) died at Coyote Ridge in January from medical neglect. He was not taken seriously until he was in septic shock. Justin should be alive today! If I hadn't gone to visit Alex, he wouldn't have lived very much longer. Guards and nurses just pass individuals by if they don't answer and not another thought is given to them.

I will not be quiet about the neglect of individuals across Washington. As a wife of an individual who was clearly neglected by the medical staff and correctional staff, I will be filing a complaint and contacting the ACLU, WA State Disability Act, Attorney General's Office, Federal Bureau of Prisons, United States Dept. Of Justice, Internal Affairs, Ombudsman of WA, and every senator and legislature who will listen. I still haven't heard from my husband or a staff member letting me know about my husband's condition. It's wrong and I want answers! I am his wife!!! I am his emergency contact!!! I deserve to know what is going on with my husband!

> *Alex Kuhnhausen had indeed been sick, and showing potential Sepsis indicators including low blood pressure, bloody cough, and confusion as early as 04/08/24.*

## REQUIRED FOR ALL INCARCERATED PERSONS IN RESTRICTIVE HOUSING

DOC 320.255 – Restrictive Housing states individuals assigned to Restrictive Housing will be provided the following Conditions of Confinement (COC), unless safety or security considerations dictate otherwise. If any of these conditions are refused or not provided, it will be documented on DOC 05-091 Daily Segregation Report. The below is not an inclusive list of the policy requirements but applicable to the basic considerations that should have and were not noted on Mr. Kuhnhausen Daily Segregation Report as delivered and/or refused in any way.

- Meals of similar quality and quantity as provided to the general population.
- Opportunity to shower at least 10 minutes and shave at least 3 times per week.
- Receive a minimum of one hour of exercise per day, 5 days per week, outside of their cell.
- Access to health care services, including medical, dental, and mental health services.
- Access to Unit Sergeant, Correctional Unit Supervisor, Correctional Mental Health Unit Supervisor, and Case manager.
- Exchange of clothing (e.g., t-shirts, underwear, socks), coveralls, and towels at least 3 times per week.
- Weekly exchange of linens.

**DOC 610.650** defines the following requirements for Outpatient Services in Restrictive Housing a qualified healthcare provider will conduct wellness checks/visits daily for individuals in Restrictive Housing per DOC 320.255 Restrictive Housing and DOC 320.260 Secured housing units. Wellness checks/visits: Must include visual observation, requested healthcare patient concerns, and noted response (e.g. verbal, movement) from every individual. Should be separate but may be included in pill line if necessary.

**DOC 420.150** requires at a minimum, one formal count of all incarcerated individuals to be conducted per 8-hour shift. Specifying that the formal count on third shift (i.e., 1400 through 2200) will be a standing count, and individuals will physically present themselves to employees (e.g., standing in the cell, walking, sitting upright) and will not be lying on the bunk or sleeping, unless a medical limitation prevents them from standing/sitting.

Facilities will establish procedures for authorization of individuals unable to participate in a standing count.

## ALEX KUHNHAUSEN'S LAST14 DAYS ALIVE

Multiple staff make note of the role of other staff during events, without those staff being interviewed directly.

### WEDNESDAY, APRIL 10, 2024 - 12 TIER CHECKS REQUIRED – 14 DAYS TILL DEATH

17:30 hours CO Ortega and CO Pena place Kuhnhausen in cell G-10 after escorting him from the Victor/Williams Unit to IMU N and completing a pre-cell inspection report.

Janelle Lavigne completes Nursing Assessment of Patient Placed in Restrictive Housing noting an allergy to Sulfa meds, current medication of Suboxone, and history of Throat Infection, Schizophrenia, and Addiction.

### THURSDAY, APRIL 11, 2024 - 48 TIER CHECKS REQUIRED – 13 DAYS TILL DEATH

Daily Segregation report commences on 04/11/24.

08:00 hrs. wellness check by RB, pill line

11:57 hrs. Shauna Baker Psychology Associate during her interview on 06/04/24, for the CIR stated on 04/11/24, she met with Kuhnhausen to complete his screening for restrictive housing, and he declined. Adding that staff do not complete the second page of form 13-349 unless they have a conversation to properly evaluate their behavior and attitude.

### FRIDAY, APRIL 12, 2024 - 48 TIER CHECKS REQUIRED – 12 DAYS TILL DEATH

0900 hrs. wellness check by B, pill line

14:30 hrs. Kuhnhausen takes his hour of yard time.

### SATURDAY, APRIL 13, 2024 - 48 TIER CHECKS REQUIRED – 11 DAYS TILL DEATH

Pill line at cell front

14:56 hrs. Kuhnhausen takes his hour yard time.

### SUNDAY, APRIL 14, 2024 - 48 TIER CHECKS REQUIRED - 10 DAYS TILL DEATH

Kuhnhausen submits Kite submitted to be seen for different medication, pill line cell front

Submits Health Services Kite requesting medical as the medication he was prescribed for his throat is making him throw up all night. Asking for different medication.

Declines yard or showers to TS

### MONDAY, APRIL 15, 2024 - 48 TIER CHECKS REQUIRED - 9 DAYS TILL DEATH

08:00 hrs. wellness check by B, pill line cell front

Declines Yard.

11:36 hrs. Leanne Davina LPN notes kite responded to, scheduled for 04/17/24.

## TUESDAY, APRIL 16, 2024 - 48 TIER CHECKS REQUIRED – 8 DAYS TILL DEATH

09:00 hrs. wellness check by B, pill line

07:30 hrs. shower taken, noted by TS.

## WEDNESDAY, APRIL 17, 2024 - 48 TIER CHECKS REQUIRED – 7 DAYS TILL DEATH

08:00 hrs. wellness check by B

13:00 hrs. Jennifer Meyers meets with him cell front noting this is due to 4 man, Sgt. unable to find staff today, Kuhnhausen agrees to cell front. Her comments note, "25-year-old presents to clinic today for follow up not feeling well. Doesn't feel like eating or drinking. Hard to make himself drink fluids. Intermittent nausea with vomiting, worst when he gets out of bed. Sleeping all day and all night. Recently came to IMU about 2 weeks ago, was injecting suboxone, states taking additional 4mg per day. Getting more suboxone from other people.

PA Meyers diagnosis him with Suboxone/Opioid withdrawal, changed his medications increasing his suboxone dosage, noted it appeared less like Thrush and more like dehydration. She did order further diagnostic labs that were to be collected on 04/19/24. Noted on 04/17/24 at 13:00 by Lindsey Lopez, Medical Assistant – no statement/not interviewed.

Declines yard time to AM.

## THURSDAY, APRIL 18, 2024 - 48 TIER CHECKS REQUIRED - 6 DAYS TILL DEATH

Wellness check by Janelle Lavigne, no time. Pill line cell front.

Declined to attend his ad-seg hearing, but ad-seg investigation notes that he did give a statement.

Psych Associate Barker added in her CIR statement that this day Kuhnhausen was okay, he worked out in the morning, there were no signs or symptoms that anything was wrong.

## FRIDAY, APRIL 19, 2024 - 48 TIER CHECKS REQUIRED- 5 DAYS TILL DEATH

Wellness check by Janelle Lavigne, no time given. Pill line cell front.

Supposed to be taken over for blood draw ordered on 04/17/24, by PA Meyers that would have likely revealed systemic infection. Michelle Glynn gives statement on 04/24/24, stating she with April Scott knew on 04/19/24, that it was imperative for this blood draw to occur. Despite delays and staffing challenges, they requested custody bring Kuhnhausen over. Custody phoned back to them and reported Kuhnhausen refused.

CUS Adams reports speaking with Kuhnhausen this date as well, and Kuhnhausen declines yard time to EM.

## SATURDAY, APRIL 20, 2024 - 48 TIER CHECKS REQUIRED- 4 DAYS TILL DEATH

Meds noted as refused. Being that Mr. Kuhnhausen was prescribed suboxone it appears unlikely that he would chose refusal and go into withdrawn. Increasing the probability that his not getting blood drawn the day prior or taking his MOUD medication mixed with not being able to move out of the bed the next day was indicative of his inability and likely disorientation to rise and engage with staff this date.

No wellness check noted.

## SUNDAY, APRIL 21, 2024 – TRANSITIONS TO MEDICAL – 3 DAYS TILL DEATH

10:28 hrs., wife Katie Kuhnhausen arrives at WSP for her scheduled visit and is informed Alex Kuhnhausen would not be able to attend as he was too weak to get up. Katie Kuhnhausen demands her husband receive a wellness check.

No meds or wellness check had yet to be completed that morning.

Wellness check on Mr. Kuhnhausen at his wife's insistence initiated.

11:22 hrs. wellness check by custody, Psych Associate Barker, and RN Tolkkein (not interviewed). Kuhnhausen was found lying on his bunk stating he was too weak to get up. Reports note, Kuhnhausen was able to move extremities actively but appeared to be weak. Mucus membranes were dry, and lips were dry and cracked. Multiple days of meals in cell, asked if eating and drinking fluids, not for two days because he can't. Can't hold his cup. Denies emesis but states he is nauseous. Assessed as dehydrated.

PA Barker added Kuhnhausen was exhibiting slurred speech, mouth was dry, and he had a hard time enunciating. His head would roll back, and his voice cracked. Sgt. Wise helped him drink some water. Kuhnhausen stated again that he had not been eating or drinking because he was too weak. Kuhnhausen reported to staff he had no food for two days and that he couldn't hold his cup.

The decision was made to admit him to the infirmary. Kuhnhausen was unable to stand or walk on his own and was transported by golf cart to the Health Services Building. RN Tolkkein later stated to PA Barker that he thought Kuhnhausens issues were mental, and he was completing a 13-420 Mental Health request.

Dora Moss reported the IMU-N nurse (not named) had called over stating he was being admitted to the IPU as "skilled care" for IV fluids. When he arrived, she sated "it was worse than she thought. He was weak. He was dry, and tachy at 135 pulse, his cheeks were sunken in. Noting after I assessed the patient, I had my coworker (Flores) call the provider back to change the order. He was so weak that he couldn't get out of the wheelchair and reported he hadn't been eating or drinking for five days to a week. Kuhnhausen stated the custody staff thought he was abusing suboxone and that was what was wrong with him.

Mike Lovejoy, RN relieved Dora Moss that afternoon. His observations note, he was getting ready to place the blood pressure cuff and the patient could not lift his arm. The patient looked like he had not slept, and his mucus membranes and lips were dry. The patient was alert and oriented and answered questions. The patient did not want medication and refused all medication (including his suboxone). The patient did not state why he was refusing but did state he had not eaten anything or drank anything in 2-5 days.

Labs were drawn. At 14:41 his heart rate was 112. Kuhnhausen's lab results returned with a white blood count of 23,000. Any level above 11,000 generally indicates a systemic infection and the risk for organ failure could begin to occur. When Lovejoy was readying Kuhnhausen for transfer his heart rate was 122, and he had spiked a fever between 100-102.

At approximately 1730 hrs. the WC (West Complex) Shift Office was notified that I/I Kuhnhausen 401534 needed to be transported to PSSMC Emergency Room by "Non-Code" Ambulance for advanced medical care. Admin DO Roberts, L. was notified.

17:57 hrs. Lt. Scott Lowder completes incident report under 24-118491, in the internal Incident Management Reporting System (IMRS) stating, "On 04/21/24 at approximately 1730 hrs. the WC (West Complex) Shift Office was notified that I/I Kuhnhausen 401534 needed to be transported to PSSMC Emergency Room by "Non-Code" Ambulance for advanced medical care. Admin DO Roberts, L. notified."

## MONDAY, APRIL 22, 2024 – HOSPITAL WATCH – 2 DAYS TILL DEATH

Update provided to Health Services from Saint Mary's Medical Center (SMMC) reports: 25-year-old with history of significant IV opiate/meth use, and depression was sent to SMMC ER on 04/21 after being found in his cell with altered mentation with possible lack of food/fluid x 2 days. In ER, patient noted to have improved mentation but found to have some abnormal vitals (specified in attached emails). Patient noted to have systolic ejection murmur on exam. Patient admitted to the hospital with diagnosis of acute bacterial endocarditis, septic embolism, acute renal failure, anemia and pleural effusion. Condition guarded.

Rachel Erickson DOC Deputy Communications Director receives an auto-forwarded email inquiry via doc.wa.gov, from Katie Kuhnhausen that evening. This is the email referenced at the beginning of Mr. Kuhnhausen's chapter. Katie Kuhnhausen's email is time stamped as sent Monday, April 22, 2024, at 9:09 PM (21:09 hrs.). Rachel Erickson forwards this email to Donald Holbrook, Assistant Secretary of Prisons stating, "FYI this will go to correspondence unit but wanted you to have a heads up in case it escalates. Would be good to make sure this individual is okay".

Erickson's response is time/date stamped as being sent on Monday, April 22, 2024, at 7:23 PM (19:23 hrs.). Two hours prior then it is date stamped as being received by the correspondence box. It is unknown why this correspondence displays different times. This email begins an extensive evaluation almost immediately with the Department of Corrections (DOC) executive leadership regarding Mr. Kuhnhausen.

At 2050 hrs., PSMMC medical staff relay that Kuhnhausen is going to be life flighted to Sacred Heart Hospital in Spokane for specialized care. Officer Miguel Jiminez on the life flight to provide security. Officer Stephen Sutton will pick up Officer Jiminez via state vehicle. AHCC Lt. Christopher Young was called, and stated Airway Heights Corrections Center (AHCC) would take over the hospital watch. WSP Administration Lonnie Roberts was notified at 2057 hrs.

21:18 hrs. IMRS incident report from 04/21/24 is updated by WSP Lt. Jesus Torrescano stating, "On 04/21/24 I/I Kuhnhausen was admitted to Providence Saint Mary Medical Center.

21:22 hrs. IMRS again updated stating: "Added: Emergency Medical Transport/Offender – Helicopter".

22:05 hrs. Kuhnhausen is admitted to Sacred Heart Medical Center.

## TUESDAY, APRIL 23, 2024 - HOSPITAL WATCH – 1 DAYS TILL DEATH

Update provided by Health Services stating: Hypotensive last night with systolic blood pressure in the 80's, required pressors/IV fluids. Lethargic and weak requiring 1:1 staff to feed. Blood culture growing GPC (Gram-Positive Cocci) in clusters, positive for MRSA (PCR). Radial arterial line had been placed, medications started, and an MRI for brain was pending to determine if encephalopathy was present.

Katie Kuhnhausen is finally notified her husband is in the hospital and arrangements are made for her and Kuhnhausen's aunt to visit but not until 18:50 hours. DOC Policy 620.200

Throughout 04/23/24, condition update emails were shared between Robert Jackson, James Key, Donald Holbrook, Sean Murphy, Ronna Cole, David Flynn, Crystal Abdulwahid, and Eric Ball.

### WEDNESDAY, APRIL 24, 2024 - HOSPITAL WATCH – TIME OF DEATH 07:18

06:00 Kuhnhausen condition declines and life saving measures are began.

06:20 Katie Kuhnhausen is notified and approved to visit.

06:50 Life saving measures begin again on Kuhnhausen.

06:52 Katie and Jacqueline arrive at the ICU.

07:18 Physician Scott Wolf declares Kuhnhausen deceased and stops life saving measures.

Throughout 04/24/24, condition update emails were shared between Robert Jackson, James Key, Donald Holbrook, Sean Murphy, Ronna Cole, David Flynn, Crystal Abdulwahid, and Eric Ball.

### AUTOPSY

04/24/24 – 8:20 hrs. - Per Policy an Autopsy was requested through Cremation Services of Spokane to the Spokane County Coroner's Office.

Despite the initial efforts of the Assistant Secretary of Health Services David Flynn, WSP Superintendent Rob Jackson, and the Chief Medical Officer Dr. MaryAnn Curl, the Spokane Medical Examiner's Office declined to complete an autopsy. When consulted by that office in the last exchanges, when asked whether Dr. Curl thought the cause of death was sufficiently established, Dr. Curl voiced her belief that an autopsy would provide no further insight. On that, the Spokane Medical Examiner made a final decline on the request to complete the autopsy.

Katie Kuhnhausen also was adamant that an autopsy be completed. To which, the medical examiner's office would only agree to complete if she privately paid, which she was unable to do.

## CRITICAL INCIDENT REVIEW

On 07/22/24, the Incident Report Review for Alex Kuhnhausen under 040-24-P was completed and signed by both Team Lead and AHCC Associate Superintendent Frank Rivera, and Deputy Assistant Secretary of Prisons James Key. It should be noted the Critical Incident Review policy under 400.110 was most recently updated and became effective on 07/23/24. As such Mr. Kuhnhausen's policy requirements remain under the version of 400.110 that was in effect from 09/24/20-07/22/24.

### INITIATION

When an incident occurs, the appropriate Assistant Secretary or their designee will determine if an incident requires a fact-finding or critical incident review and initiate the review as applicable.

## CIR FACILITY TEAM CHOICE

Mr. Kuhnhausen had been incarcerated at the Washington State Penitentiary – Intensive Management Unit North (IMU N) at the time he became ill. Kuhnhausen transferred to the inpatient health unit on 04/21/24, the local hospital in Walla Walla later that day, and then was later transferred via airlift to Spokane for critical care on 04/22/24. Staff from the Airway Heights Correction Center (AHCC) met the airlift.

The Incident Summary of the Incident Review Report states: "AHCC Lt. Young Christopher was called, and he stated AHCC will take over the hospital watch. WSP Administrator Roberts Lonnie was notified at 2057 hours."

On 04/24/24, at approximately 0740 hours AHCC staff notified WSP that Kuhnhausen had passed away at 0718 hours at Sacred Heart Medical Center in Spokane. Administrative Duty Officer Lonnie Roberts made notification at 0745 hours.

## INVESTIGATION CONCERNS

Department of Corrections (DOC) Policy 400.110 states the Critical Incident Report (CIR) will contain:

- Finding of fact,
- Contributing factors,
- Root cause analysis,
- Proposed Mitigation steps, and
- Future Risk analysis

## FINDING OF FACT INCOMPLETE

The Department of Corrections (DOC) produces a Critical Incident Report Review Guide. Section 3 of that guide is titled "Incident Evaluation" stating and leading the future report writer through the Key Elements of Fact Finding.

Incident Narrative: "Think and write like an investigative journalist – tell the story of the incident. Do not copy and paste other reports in here. This is the place for synthesizing all the source reports into one coherent narrative".

Contributing Factors: "How did this happen"?

Root Cause Analysis: Why did this happen? Lace your 'therefore' statements from the '5 Whys" worksheet for all listed concerns.

The Choice and Integrity of Critical Staff Interviewed DOES NOT present a clear picture of the facts leading to Alex Kuhnhausen's death. It provides inaccuracies and inconsistencies and leaves many questions unanswered.

## EXPECTED OR UNEXPECTED DEATH NOTIFICATION

Investigations Duty Officer Ciara DeVink stated: "Kuhnhausen's death was reported to her as an "expected" death. That IIU was not notified of the initial transport to the outside hospital, or the subsequent hospital move. Due to the death being reported as "expected", DeVink reported they responded accordingly as IIU is not required to respond to deaths listed as expected, as they are unlikely to be criminal. This resulted in no crime scene review, no information being gathered, or law enforcement notification being made."

Devink clarified in her CIR interview with Heather Luck on 06/03/24, "at the time of Kuhnhausen's death she was IIU Duty, she stated that she received a call from Shift Lt. Alaina Jordan after Kuhnhausen had passed away, at approximately 0734 hrs. on 04/24/24.

She stated that Lt. Jordan reported to her that this was "expected" and was due to Kuhnhausen being sent to AHCC for additional medical care for "ongoing medical issues" or an "on-going" illness.

Reviewing the electronic incident report under 24-118491 from the internal Incident Management Reporting System (IMRS) that was updated throughout Kuhnhausen's last days reveals the initial incident report was submitted on 04/21/24 at 17:57 hrs. by Lt. Scott Lowder at the Washington State Penitentiary (WSP) listing the incident type as Emergency Medical Transport/Offender.

The narrative entered states, "On 04/21/24 at approximately 1730 hrs. the WC (West Complex) Shift Office was notified that I/I Kuhnhausen 401534 needed to be transported to PSSMC Emergency Room by "Non-Code" Ambulance for advanced medical care. Admin DO Roberts, L. notified."

The IMRS was subsequently updated on 04/22/24 at 21:18 hrs. by WSP Lt. Jesus Torrescano stating, "On 04/21/24 I/I Kuhnhausen was admitted to Providence Saint Mary Medical Center. On 04/22/24 at approximately 2050 hrs. PSMMC medical staff stated that I/I Kuhnhausen was going to be life flighted to Sacred Heart Hospital in Spokane for specialized care. Officer Jimenez Miguel on the life flight to provide security. Officer Sutton Stephen will pick up Officer Jiminez via state vehicle. AHCC Lt. Young Christopher was called, and he stated AHCC will take over the hospital watch. WSP Administration Roberts Lonnie was notified at 2057 hrs. Then at and 21:22 hrs. updated again with: "Added: Emergency Medical Transport/Offender – Helicopter".

The IMRS was last updated by WSP Lt. Alena Jordon on 04/24/24 at 9:33 AM and 9:38 AM stating:

"On 04/24/24 at approximately 0740 hours AHCC staff notified WSP that I/I 401534 Kuhnhausen had passed away at 0718 hours at Sacred Heart Medical Center in Spokane. Administrative Duty Officer Lonnie Roberts notified at 0745 hours, Medical Duty Officer Jaris Alcon notified at 0750 hours, HQ Duty Officer Scott Russell and James Key Deputy Assistant Secretary were notified at 0800 hours, Records Manager Michelle Alexander notified at 0748 hours. The Spokane Coroner's Office was contacted, and body released to them at 0820 hours. Autopsy was requested through Cremation Services of Spokane to the Spokane Coroner's Office."

WSP Lt. Jordan updated the IMRS again at 09:38 AM stating: "Updated Type: Death of Offender – Unexpected".

## RESPONSE VS RESULTS

It warrants further questions on how anyone would have relayed this as an "expected" death to begin with. Far less, how executive prisons leadership didn't begin investigating immediately. Especially considering the two prior deaths occurring at WSP in the months before Kuhnhausen's, and the concerns expressed by another family about the response to their loved one in the IMU just weeks beforehand.

The electronic incident report for Kuhnhausen submitted by Lt. Lowder on 04/21/24, was updated multiple times on 04/22/24 and 04/24/22, by Lt. Alaina Jordan and Lt. Jesus Terrescano. Each update of the incident report would have driven new electronic notifications to a distribution list that includes a wide range of Department staff to include executives and facility investigations staff.

Each week on Monday, Wednesday and Friday mornings all Department of Corrections (DOC) executives review the IMRS reports of note. An individual being so medically impacted that they cannot attend a visit or eat/drink that is then admitted to an institution's infirmary and then the hospital, then subsequently life flighted for a higher level of care at a different hospital, is without a doubt not an everyday occurrence and it did not go unnoticed at the facility or executive level.

The email that Katie Kuhnhausen sent on 04/22/24 at 7:09 PM to the Department of Corrections (DOC) Correspondence email box was forwarded from Deputy Communications Director Rachel Ericson to Assistant Secretary for Prisons Don Holbrook within the hour at 7:23 PM. Assistant Secretary Holbrook then forwarded that email to his superior Deputy Secretary Sean Murphy at 7:48 PM, who then forwarded it to Assistant Secretary David Flynn over health service. The emails continued to move down the chain to facility leadership who were providing regular updates.

On 04/23/24 at 7:23 AM, this email chain had grown and a response from WSP Superintendent Robert Jackson with the initial fact finding was sent to Deputy Assistant Secretary's for Prisons James Key, Assistant Secretary for Prisons Donald Holbrook, Assistant Secretary for Health Services David Flynn, Deputy Secretary for the Department Sean Murphy, Deputy Assistant Secretary for Health Services Ronna Cole, WSP Health Services Manager Crystal Abdulwahid, and WSP Facility Medical Director Dr. David Ball.

Jackson provides a timeline of events that cover the same major facts known today of the timeline, the reality that hospital staff were already clearly stating how critically ill Kuhnhausens was, and the view his condition was guarded. This update includes information from medical and custody staff, and notes at the top," All, this is what I have thus far. Waiting on a response from CUS Adams, CC3 Coers and CPM Lomeli. Will send their responses once I get them."

Superintendent Jackson was already completing fact finding that should have clearly driven Assistant Secretary James Key to initiate a CIR immediately upon Kuhnhausen's death. Where this intentionally or unintentionally fell apart is not known.

## IIU INVESTIGATION

IIU reports not having Kuhnhausen on their radar, but Lead Investigator Juline Norris had opened a case for testing of the syringe that had been found in his possession on 03/28/24. Norris also completed an incident report on 04/03/24 for use in Kuhnhausen's infraction hearing that followed. Kuhnhausen was also on IIU's list to interview the week he died regarding his Security Threat Group affiliation concerns. It seems implausible that an incident of this profile would not have had everyone checking connections at a facility level as they were at an executive level.

Juline Norris reports to the same Associate Superintendent Sandi Jacobson that the Facility Capitan's do that oversee all the facility Lieutenants. Facilities generally hold daily operations briefings among shits and different operational groups. While not noted in Investigator Devink's statement, the IMU Summary states," IIU was only notified of the death and not expected to respond. IIU did after the fact, monitor communications from Kuhnhausen and did not find anything alarming in said communications. They were concerned after, noting he was young and should not have been so ill that he was expected to pass. Due to the reporting of the death as "expected" IIU did not continue an investigation nor open a case file. IIU believes there was a lack of communication between multiple parties to include custody staff, the LT's and the multiple facilities that were involved in this situation.

From the time that the syringe from Kuhnhausen was recovered on 03/28/24, to the day of his death IIU reported Kuhnhausen made 250 phone call attempts, 114 of those were completed calls (this also includes multiple video visits). In that same time frame 52 Jpay messages were sent/received by Kuhnhausen, only 2 were sent by Kuhnhausen. On 04/10/24, Kuhnhausen received a message from his "wife" Katherine "Katie" Kuhnhausen, in this message it is stated that she was concerned about him, and she knew he was sick and was hoping to he'd be able to get his "test results" back and that he would be able to get on some antibiotics. Following that, another message was sent by Katherine on 04/12/24 which shared she knew and was aware he had an infection.

After 04/10/24, there were no messaged sent from Kuhnhausen as he was placed in IMU, and his tablet was not issued back to him at that time. Clearly Mr. Kuhnhausen regularly made multiple calls daily to his wife. After 04/13/24, Kuhnhausen allegedly declined all his yard opportunities that would have allowed him to contact his wife.

After his death, Katie received two phone calls from other incarcerated individuals. On 04/27/24, at approximately 2006 hrs. Katie describes what she had been told and what had been done with Kuhnhausen up to the time of his death while in Department of Corrections (DOC) custody. She describes that Kuhnhausen had not contacted her in 6 days and that she came to WSP to visit him, and he never came out because he was found "half paralyzed because the embolism was blocking", she stated that he was almost incoherent. She claims that he was taken to the prison hospital and not an outside hospital initially but was then transferred. She claims that Kuhnhausen had told her that he was never placed on antibiotics, and he had been sick for a month and a half. She claims that blood work was never done.

### CORRECTIONAL OFFICERS INTERVIEWED

The Correctional Officers interviewed included: Kurtis Grinrod, Carlos Leos, Megan Sumerlin, and Sgt. Joe Swanson all speak to how the MOUD pill lines that distribute medication operate, and their roles. Those staff are exclusively assigned to the Victor/Williams Medium Custody Unit movement officer positions where Mr. Kuhnhausen was residing prior to his custody demotion and placement in the Intensive Management Unit (IMU). These custody staff exclusively interacted with Kuhnhausen in his last unit and not while he was placed in the IMU.

The only custody officer staff interviewed that did work in the IMU was Sgt. Todd Wise. Within the IMU structure is Correctional Program Manager Alfredo Lomeli Jr., Correctional Unit Supervisor (CUS) Ann Adams position is below his, and she direct reports to Lomeli. CUS Adams has Sgts. Todd Wise and Aaron Kershaw, and Classification Counselor 3 Jon Coers report to her as the CUS.

Reporting to Sgt. Wise is the following nine Correctional Officers (COs): Eduardo Michel, David Cervantez, Ariel Olson, Donoan Kozachenko, Tanner Siller, Miuel Jimenez, Joseph Leonetti, Stephanie Saldana, and Joseph Decoto.

Reporting to Sgt. Kershaw is the following nine other CO's: Abel Pena, Jazmin Montoya, Israel Valencia, Joselyne Rodriquez, Noan Velazquez, Raymond Troup, Jacob Harshman, Williard Palmer, and Daniel Espana Vasquez.

None of the custody officers in IMU N were interviewed for the Critical Incident Review.

## POLICY BOUND CUSTODY OFFICER RESPONSIBILITIES FOR IMU

### TIER CHECKS

Custody Officers (CO's) are responsible for visually checking on incarcerated individuals every 30 minutes in the IMU. According to the Security Inspection Matrix attached to Department of Corrections (DOC) 420.370: Visual cell front checks or "Tier Checks" that include a walkthrough of the units where COs complete a visual observation of condition and activity of cell/rooms occupants at least every ½ hour. Those Visual checks would then be logged into the unit logbook.

No incident reports were completed by custody staff according to the CIR about the overall circumstance of finding Mr. Kuhnhausen in the state he was on 04/21/24. A noted custody Improvement Recommendation is a mechanism being put in place for incident reports to be completed when there is a medical transport to an outside facility. The CIR team also failed to report on any review of the logbook for IMU N Tier Checks, or the compliance of custody staff with completing required Tier Checks that should have informed Kuhnhausen's declining physical condition.

In the classification section of the improvement recommendations there is mention that no logbook entries were noted for Kuhnhausen's assigned classification counselor Jon Coers in the logbook as required by Department of Corrections (DOC) policy. Clearly indicating the logbook was reviewed, but no findings were noted regarding custody staff.

None of these CO's listed above or Sgt. Kershaw completed incident reports or had their duties checked against the logbook.

## APPROPRIATE EXPERTISE

It should be noted the critical incident review policy states, review teams will consist of at least 3 people with relevant subject matter expertise regarding Department policies, procedures, and practices. James Parker who served as the co-team leader of this investigation is presently the Facilities manager at AHCC. Since beginning his career in 2009, he has worked exclusively in facilities/plant management, and as an industries manager for Correctional Industries. He has no custody or classification experience listed, which may have left him unaware of the requirements he would need to check for custody staff in an IMU setting. Although Department of Corrections (DOC) policy clearly would have.

## CELL SEARCHES

Thorough inspection of security hardware, to include interior/exterior doors, bars, walls, floors locks, fixtures, ceilings should have been completed on Mr. Kuhnhausen's cell 4 times monthly (every 7 days).

The CIR references Mr. Kuhnhausen be placed into the IMU on 04/10/24, and that a 05-091A was not started until 04/11/24. The first entry on this form was a "wellness check". IMU north uses a weekly search log with each mod and cell listed on it. The searching staff records the date the cell was searched in the square that represents the cell then adds their initials. They also complete a search report. CUS Adams audits the log against the search reports weekly. Any discrepancies are sent ack to the Sgt. to remedy. Discrepancy noted in the CIR: Intake into IMU was 04/10/24, 1st documented cell search was recorded 04/20/24. No documentation was located showing if G10 west was searched after it was vacated prior to I/I Kuhnhausen being placed in G10 West.

Reviews of Mr. Kuhnhausen's available documentation show that a WSP IMU N search report was completed on 04/10/24 for cell G-10 at 17:30 hours by CO Ortega and CO Pena who escorted Kuhnhausen from the Victor/Williams Unit to the IMU. No search report exists for the stated 04/20/24 search, although the handwriting could have been mistaken the #1 for a #2 on the form. Follow up with escorting staff would confirm this form belonged to 04/10/24. A search on 04/20/24, would have likely revealed a notable decline in Mr. Kuhnhausen's health.

## DUPLICATED AND CONFLICTING FORMS

On 04/21/24, an entry is placed on the log began 04/11/24, as well as a second on a new log began 04/21/23. The 04/11/24, log is completed by Sgt. Wise and states for 04/21/24: "Sent to HSB". This log is signed off for at the end of the week on 04/23/24, by Sgt. Wise. The log began on 04/21/24, is initialed by "Ed 7898" stating "dinner refused" with 1700 being the indicated time. This log is stamped Sgt. Abel Ureno 7296 on 04/29/24. The dual statements were not asked about during any interviews.

The presence of logging twice for the same day is troubling as one clearly states he is not in the unit, and the other is stating Kuhnhausen had refused dinner at 1700, when he had definitely been transferred to health services building since 11:35 hrs. His last hours to be spent alive within the prison were from 11:35 hrs till approximately 17:30 hrs. when he transferred from Health Services out to the hospital. Kuhnhausen was not available at 17:00 hrs. to refuse dinner.

## IMU LEADERSHIP CONTACTS

CPM Lomeli and CUS Adams both made statements about contact with Kuhnhausen or Katie that could not be verified. Notably, CUS Adams reported that on 04/19/24, that she made cell front contact with Kuhnhausen and asked him to call his wife, and he confirmed he understood her request. When asked if she noticed anything concerning, she relayed that he was sleeping when she first approached, but she was able to wake him up, but he was still a bit sleepy.

Sgt. Reed reportedly joined this conversation with CUS Adams, and she reports Sgt. Reed was familiar with him from his prior unit. When the cell front meeting concluded, Sgt. Reed purportedly made the assessment that Kuhnhausen seemed to be on his normal baseline behavior. Sgt. Reed provided no statement and was not interviewed during this investigation.

CUS Adams, provided an email response to Superintendent Rob Jackson on 04/23/24, that stated after Kuhnhausen's hospitalization, she reviewed video from IMU N days prior to his move to Health Services. Looking specifically at his movements to Yard/Showers. Her assessment was Kuhnhausen appeared well in the video. No video of his transport to the Health Services on April 21st was reviewed nor was this video recorded. CUS Adams states no video recordings were requested or pulled. By the time the CIR was assigned, CUS Adams stated the video had been recorded over due to the retention schedule.

It should be noted that Mr. Kuhnhausen died on 04/24/24, and the Attorney General's Office sent the Department of Corrections (DOC) a preservation hold notice for all records related to him on 04/30/24. It is unlikely the records would not have been preserved six days post incident. If so, this maybe an area in need of systemic corrections.

## MISSING STATEMENTS

On 04/23/24, CUS Adams sent an email to Superintendent Jackson that summarized on 04/19/24, Sgt. Reed had come over to help her and it was super busy with lots of 4-man's going on from the weapon ERT find. They had their previously noted chat. CUS Adams also noted she spoke with their unit nurse and our regular officer that morning. As far as custody goes, during their tier checks Kuhnhausen was sleeping (not unusual for guys in here) or acknowledged staff with no indication that anything was wrong. Davina, our regular nurse reported the Kuhnhausen participated in pill line last week with no indication that anything was wrong.

However, she did note that he declined to take his other medications and would only take his suboxone. She did report the decline of other medications, and that he had been to sick call on the 17th and other staff were reporting he gave no indication that he was sick and treated appropriately based on the conversation. Clearly, he was reporting he was sick on the 17th, and it appears CUS Adams was not summarizing and forwarding along the correct facts.

## IMPROPER RESPONSE TO MEDICAL REFUSALS

Per DOC 610.010 Patient Consent for Health Care, Refusal of Services: Except for services provided by the Substance Abuse Recovery Unit or the Sex Offender Treatment and Assessment Program, if the patient refuses health care that was recommended or previously consented to and requires written consent, health services employees/contract staff will document the refusal on the appropriate medical, mental health, or dental encounter/progress form and forward the patient's health record to the order practitioner/protocol provider for review.

The ordering practitioner/provider will a) schedule an appointment with the patient to discuss the refusal, health consequences, and alternatives, and b) document the refusal on the appropriate medical, mental health, or dental encounter/progress form, and c) complete DOC 13-048 Refusal of Medical, Dental, Mental Health, and/or Surgical Treatment. This never occurred and it unknown to what extent custody staff made efforts, although clearly this was not a followed process nor was Kuhnhausen's health a priority to the custody staff.

## CRITICAL INCIDENT REVIEW TEAMS

**Team members must not:**

- Have witnessed of participated in the incident.
- Be selected from the office or facility under review.
- Otherwise appear to have a conflict of interest

## ASSEMBLED TEAM

The CIR Team was led by Frank Rivera – Associate Superintendent at AHCC and Co-led by James Parker – Facilities Manager. Team Members, Nancy Fernelius – Clinical Nurse (HQ), Kevin Lightbody – Classification Counselor (AHCC), Heather Luck – Investigator 2 (WCC), Mikaba Snowden – Registered Nurse 3, Shawna Snyder – Corrections Specialist Assistant (AHCC), and Young, Chad – Lieutenant (AHCC).

Frankly, any staff with Airway Heights Corrections Center, as that facility also assisted in the series of events from hospitalization of Mr. Kuhnhausen till his death, appear to have a conflict of interest in participating.

Reconciling the staff listed against Department of Corrections (DOC) records clarifies that Team Member Chad Young – Lieutenant (AHCC), is indeed Christopher "Chad" Young. The same individual listed in the Incident as arranging the hospital watch coverage with the Washington State Penitentiary (WSP) two days prior. Roberts Lonnie and Lonnie Roberts are one in the same person and his name is officially Lonnie Roberts.

## LT. CHAD YOUNG

Chad Young, however, has dual conflicts participating in this event. Lt. Young assisted WSP staff in the coordination of hospital watch, which is not entirely clear at first look in the CIR as his legal first name, "Christopher" is used with "Young" and written reversed as Young Christoper. A check of Department of Corrections (DOC) records shows that Chad Young and Chris Young are one and the same person. Mr. Young is even listed as "Chad" along with his full name in the Department of Corrections (DOC) directory. The use of his legal name in one location and the casual name he uses in another location, could even generate suspicion that his initial involvement was intentionally disguised.

Secondly, Lt. Young was a coworker for nearly a year from 2019-2020 with Juline Norris, the current supervisor of the investigation staff that did not initiate an investigation in Kuhnhausens death due to "erroneous" info provided by AHCC staff.

Chad Young is listed as completing the custody interviews for Kurtis Grindrod, Carlos Leos, Megan Sumerlin, Joe Swanson, and Todd Wise. Chad Young prior to promoting to his current position as Lieutenant at AHCC in August of 2020, held the position of Corrections Specialist 2 under Department of Corrections (DOC), at the Washington State Penitentiary (WSP).

Chad Young while working as a Correction Specialist 2 at WSP, was employed in two different positions that he swapped with Julie Norris. After Young left WSP, Norris also promoted in 2021, to her current position of Lead Investigator/Investigator 3 at WSP. A position that currently supervise Ciara Devink – Investigator 2 who later claims in her statement that she did not initiate an investigation in Mr. Kuhnhausen's death because she was erroneously informed the death was "expected".

## STAFF CREDIBILITY CONCERNS

Ms. Perkinson is the Washington State Department of Corrections (DOC) Critical Incident Review (CIR) Manager responsible for the coordination of investigations and reports. Ms. Perkinson stipulated in July 2024, to misuse of state property as well. In addition to the civil penalty, she received she also received a demotion from her prior position of Director of Engagement to her current position as CIR Program Manager.

Deborah Roberts who serves as the Headquarters Sentinel Events Manager responsible for coordinating and tracking the Unexpected Fatality Review Process began her position on 06/01/23. It should be noted she previously held positions from 2019-2020 as the Deputy Assistant Secretary of the Department of Social and Health Services, Developmental Disability Administration (DDA). Where she authored that agency's much more detailed policy on mortality reviews of individuals who died in DSHS's care in 2019.

On May 1, 2020, Ms. Roberts was promoted by Cheryl Strange (in her prior role as DSHS's Secretary) to the position of Assistant Secretary over DDA. Ms. Roberts remained in that position until 03/06/23, when she submitted her same day resignation. On 03/21/23, in a highly reported ruling, DSHS and the Washington Attorney General's office were jointly fined $200,000 for failing to provide 11,000 pages of discovery in a negligence case brought against the Developmental Disability Administration for their failures to protect Emily Tobin. All of which occurred under Ms. Roberts tenure leading that administration.

## ONGOING PROCEEDURAL CONCERNS

Prior to succumbing to his illness, Katie Kuhnhausen states that her husband Alex was able to relay what happened before he was found on 04/21/24. Alex Kuhnhausen stated he hadn't refused things he was just asleep. Citing a practice that exists within the IMU at Walla Walla that staff don't wake you up, and they count it as a refusal of an activity if you are not standing by your door as required to affirm that you want to take a shower or go to yard. Katie Kuhnhausen is adamant that her husband did not leave his cell after his sick call on 04/17/24. That he informed her hadn't showered in 8 days when he was found, and that he wasn't strong enough to eat or drink water in his last days. Katie contends there is no possible way that staff could have completed a cell search on 04/20/24, and not have noticed her husband's condition as he would have been unable to get out of bed.

Substantiating this concern, in a prisoner rights complaint filed in 2023 by Robert Hill, under Eastern District of Washington case: 4:23-cv-05143-SAB. The complaint by Mr. Hill includes public disclosure of a Levell III Resolution Response under LOG ID Number 2274 6601.

This resolution was originally filed 06/10/22, and has a final resolution signed on 07/21/22, by Jeffrey A. Uttecht, former Washington State Department of Corrections (DOC) Deputy Assistant Secretary of Prison.

This complaint raises concerns with CO Pinza and Sgt. Wise. Mr. Hill's description is as follows: "There is no policy or O.M. (Operational Memorandum) that requires this ongoing procedure of asking sleeping incarcerated individuals on 2nd Shift whether or not they want their yard-hour. There is no policy of O.M. authorizing Pinza to assume my "non-response" (while sleeping) should be constructed as a refusal or a "no". Pinza failed, or refused to make sufficient effort or attempt to wake me up so that I could affirmatively say Yes. He ignored the sign at the bottom of the door-window that said "Yard-Yes!" These actions of procedure cumulatively show an effort to STEAL yard-hours; with the result being less work to do. Suggested remedy: 1. Written apology from Pinza and Wise (in the written Prisoner Rights Complaint hill attributes this policy to be Sgt. Wise's creation). 2) Elimination of the 2nd shift question-procedure; and utilization of a two weeks published schedule, like Clallam Bay uses."

## DEPUTY ASSISTANT SECRETARY UTTECH'S RESPONSE STATES AS FOLLOWS

Your Level 3 appeal concerning a staff member and your yard time was reviewed by, CS4 J. Richer. All Resolution requests and any appeals were reviewed during this process. It was noted that you were interviewed on 02/17/2022, and those who provided statements were spoken with on 02/16/22, and 05/05/22.

Having reviewed all the information, the department has concluded that the information does not substantiate any policy violations or items that would construe misconduct. As previously stated, while the staff is required to make a concerted effort, it is the responsibility of the individual to provide a verbal answer. While the incident may be unfortunate in that you were unable to speak with a family member, the current information does not indicate the current process is sued to circumvent individuals "Yard Time". Or that offices engaged in any action to support the process of "Stealing Yard Time".

While the allegation was ultimately found un-substantiated for "Stealing Yard Time", it did clearly place responsibility for a response on the individual. It does ultimately beg the question, what was considered a concerted effort, and how many concerted efforts had to be made to a sleeping person, before concerns elevated.

## CONSIDERATIONS

Mr. Kuhnhausen's death tragically stands as a prime example of why natural deaths in prison should require a thorough independent investigation including autopsy outside very narrow exceptions, i.e. diagnosed terminal illness. The prison environment is different than any other. It is inherently dangerous, the environment is controlled, and individuals and staff lack visibility.

**Determining the Exact Cause of Death:** While the death may initially be classified as "natural," an autopsy can reveal the specific medical cause. It may uncover underlying conditions that were not properly diagnosed or treated, such as heart disease, infections, or other medical issues that could have been preventable with appropriate care.

**Investigating Possible Neglect or Inadequate Care:** In a prison setting, medical neglect or substandard healthcare can contribute to otherwise "natural" deaths. An autopsy can help identify whether the prison's medical staff failed to recognize or address a serious medical condition that led to death, potentially revealing systemic issues within the prison healthcare system.

**Preventing Cover-ups:** Autopsies can help prevent potential cover-ups of wrongful deaths, especially in cases where there may be a question about the adequacy of medical treatment or other contributing factors like excessive stress, poor living conditions, or abuse. Incarcerated individuals are in a controlled environment, so it's important to thoroughly investigate any death to ensure no foul play or negligence occurred.

**Addressing Family Concerns:** Families of incarcerated individuals often seek closure and answers. An autopsy can provide more clarity about the circumstances of death and offer reassurance or evidence if there is a concern about mistreatment or neglect.

**Legal and Accountability Reasons:** In cases where a wrongful death lawsuit or an investigation might be considered, an autopsy is critical in gathering the necessary evidence. If medical malpractice or neglect contributed to the death, the autopsy report will be a key piece of evidence in the loss prevention planning for the Department.

**Preventing Future Deaths:** If the autopsy reveals systemic issues related to safety or medical care in the prison, it can prompt reforms and improvements that may prevent future deaths.

### INJECTION DRUG USE

Alex Kuhnhausen admitted prior to his segregation placement to injecting suboxone with a homemade needle. Injection drug users face numerous significant health challenges due to the nature of drug use and its associated risks.

The most common health issues include:

HIV/AIDS AND HEPATITIS B AND C: Shared needles and unsafe injection practices significantly increase the risk of bloodborne infections like HIV and hepatitis. A large proportion of injection drug users are infected with one or more of these viruses (American Heart association).

BACTERIAL INFECTIONS: This includes infective endocarditis, abscesses, cellulitis, and osteomyelitis due to non-sterile injection techniques (BioMed Central).

OVERDOSE: The risk of overdose is high among injection drug users, particularly with potent opioids like fentanyl. Overdoses can result in respiratory failure, brain damage, or death. (BioMed Central).

MENTAL HEALTH DISORDERS: Many injection drug user suffer from co-occurring mental health disorders, such as depression, anxiety, and post-traumatic stress disorder (PTSD). These conditions can exacerbate drug use and make it difficult to seek or maintain treatment (American Heart association).

PULMONARY COMPLICATIONS: Drug users, particularly those who inject drugs, may develop pneumonia, pulmonary embolism, or hemoptysis (coughing up blood), particularly if substances are injected into veins that drain to the lungs (BioMed Central).

CARDIOVASCULAR ISSUES: In addition to infective endocarditis, injection drug users can suffer from deep vein thrombosis (DVT) and pulmonary embolism, especially when injecting into non-traditional veins (BioMed Central) (BioMed Central).

SUBSTANCE USE DISORDER (SUD): Addiction itself is a major health challenge, leading to a cycle of use, health deterioration, and social consequences. Treatment is complicated by stigma, limited access to care, and the chronic nature of addiction (American Heart Association).

MULTIDISCIPLINARY APPROACH: Addressing these health issues requires a multidisciplinary approach, including access to harm reduction services, addiction treatment, and comprehensive healthcare.

## INFECTIVE ENDOCARDITIS

Injection Drug Use associated Infective Endocarditis represents a considerable proportion of overall cases of Infective Endocarditis, mainly affecting young people. Staphylococcus aureus is the most common microbiologic agent. This subset of infective endocarditis is not associated with higher short-term mortality, but drug abuse is an independent predictor of long-term prognosis. The main determinant of long-term prognosis in injection drug use associated infective endocarditis is drug abuse itself. Thus, increased focus on addiction treatment starting early during hospitalization is mandatory to improve long-term survival.

There are more than 35,000 cases of infective endocarditis per year in the U.S.

About one in five people with infective endocarditis die from the infection.

Heart valves do not have a direct blood supply, so the body's immune response can't reach them, making valve infections difficult to treat.

The infection can come from many sources, including poor dental hygiene, implanted medical devices, chronic skin disorders, burns, injection drug use, and more.

A study of U.S. health information from 2002 to 2016 found that the proportion of patients hospitalized with infective endocarditis related to injection drug use doubled from 8% to about 16%.

People with infective endocarditis related to injection drug use are younger, with an average age of 38 years, compared to those who do not inject drugs. Most people with non-drug related infective endocarditis are older than age 45 years, with one-third older than the age of 69 years.

Infective endocarditis has been observed at higher rates among injection drug users in correctional settings

Studies indicate that Injection Drug Users in correctional environments are at significant risk due to continued intravenous drug use, often under less-than-ideal sanitary conditions, combined with delayed or limited access to appropriate medical care. For instance, a study conducted in Virginia found that between 2000 and 2016, the number of cases of Infective Endocarditis related to injection drug use increased dramatically, with a 7.54-fold rise in admissions for injection drug use associated Infective Endocarditis.

Furthermore, research highlights the compounded risks injection drug users face in these settings, such as lack of timely medical intervention and underlying issues like homelessness, limited access to addiction treatment, and high relapse rates for those in the violator populations. A study also found that approximately 45% of injection drug use patients were uninsured, further limiting their access to appropriate care.

## ROOT CAUSE CONSIDERATIONS

Each of these cases highlights that root cause analysis for creating safer institutions and ensuring sufficient medical care must extend beyond the immediate moment of the incident. In narrowing the scope to the circumstances surrounding the incident itself we lose the complex connections of systems and processes at play with a human life. While this approach may address short-term concerns, such as mitigating financial risks from litigation, it fails to uncover deeper systemic issues. Without a comprehensive evaluation and systemic improvements, the opportunity to build safer, more effective systems is lost.

## DEATH 5: DANIELLE REYES – 06/23/24 – WCCW

On June 23, 2024, during the morning hours at 0620 Tier checks were conducted by CO Gomer and CO Doleman and documented that Danielle Reyes appeared live and well on her bunk. Tier Checks were continued by Doleman that was assigned on West Pod at 0700 and 0813 hours, until Doleman requested she swap posts with CO Molinero. Sgt. Robinette approved this swap in posits and the exchange took place.

Molinero completed a tier check of West Pod at approximately 0908 hours upon arrival in the unit and stated Reyes was alive and standing by the bunk. Molinero conducted another tier check at 1010 hours. At approximately 1027 hours Molinero conducted another Tier Check at 1010 hours. At approximately 1027 hours Molinero attempted to contact Reyes at cell front and received no response.

CO Gomer was assigned to the East Pod and responded to the West Pod to Cell 228 once emergency radio traffic was initiated at 1028 hours. CO Gomer stated that it was very dark in the cell and that he had to turn on the light to see what was happening. CO Gomer and CO Molinero made cell entry and found that Reyes was unresponsive laying prone towards the bunk with a shoelace tied tightly around her neck and then tied on the middle rung of the ladder to the top bunk.

CO Gomer immediately placed his arms under Reye's armpits and lifted her body to relieve tension from the shoelace while CO Molinero was able to untie the shoelaces from the middle rung but unable to untie the shoelace around her neck. At this time, CO Hudson arrived at Cell 228 West Pod and was told to get a cut down tool from the booth. CO Gomer laid Reyes supine on the floor and placed two fingers in between the shoelace and neck to allow air flow.

CO Hudson returned to Cell 228 with the cut down tool and cut the shoelaces away from Reye's neck. CO Gomer began life saving measures and started chest compression while CO Molinero gave rescue breaths. After four cycles of chest compressions CO Hinz took over compressions. During this time, I/I Callahan stated that I/I Reyes had a DO No Resuscitate (DNR) order on file. Compressions were stopped due to confusion if suicide counted for a DNR or if it was just natural causes. A decision was made to resume CPR because no one knew the answer.

At approximately 1030 hours LPN 4 Ward arrived with the stretcher and red bag with Sargeant Way. LPN Ward retrieved a new OPA from the red bag for Reyes due to the one the CO's had been inefficient. LPN Ward returned downstairs to retrieve oxygen and the Ambu bag and to clarify the DNR and to continue CPR. 911 was activated by Sargeant Elizares at approximately 1032 hours.

RN2 Maniatopoulos arrived at Cell 228 at approximately 1035 hours and placed the AED on Reyes while officers continued CPR. RN2 Vincente arrived on scene and helped the correctional officers with CPR until EMS arrived.

Pierce County Medic One arrived at West Pod Cell 228 cell front and took over life saving measures at approximately 1040 hrs. The paramedics established Intraosseous access in both knees and administered medications. EMS attached the CPR machine that does chest compressions, and continued CPR for about 30 minutes. RN2 Vincente gathered all paperwork ready for her to be transported to the hospital.

At approximately 1108 hrs., time of death was pronounced by EMS. During this time a Death of Incarcerated Individual checklist was initiated, and a crime scene was established with CO Ellington as watch office.

Duty Officer Captain Rio authorized notification of Resilience Support Team (RST), staff accountability, and picture card count. All required notifications were made.

## CRITICAL INCIDENT REVIEW

A mental health review was completed. Reyes had recently completed intensive outpatient treatment but was continuing to meet weekly with Dr. Brodie for individual therapy. Reyes had reportedly been struggling with her feelings however, she denied feeling suicidal or having thoughts of self-harm and planned to meet with her psychiatric provider every 90 days for medication management with the goal of discontinuing her medications once she was psychiatrically stable.

In reviewing her Securus call logs and in interviews with incarcerated individuals known to be close to Reyes, a common theme emerged that Reyes frequently spoke of suicide and had a desire to end her life. Although at the time of her death there had been no signs that she had imminent plans to end her life.

A classification review was conducted and placement of Ryes at WCCW as appropriate.

## DO NOT RESCESSITATE (DNR)

According to Ms. Reyes's Critical Incident Review, a note is made regarding 420.025 Department Identification Cards: "I/I Reyes issued identification card noted that she was DNR. Clarifying education for both custody and health services staff regarding any exceptions, i.e. suicide/self-harm."

Improvement recommendations state: Responding officers stopped and resumed life saving measures because there was confusion caused by the DNR prescribed to I/I Reyes. Recommendation for staff to review Policy 620.010 Advanced directives. Which differs from the above recommendation but remains more applicable.

## DOC POLICY 620.010

Withholding or Withdrawing Life-Sustaining Treatment. For medically necessary and indicated life-sustaining treatment to be withheld or withdrawn: The incarcerated individual must have a valid DOC 13-311 Health Care Directive or equivalent for health care on file, and there must be a diagnosis of a terminal condition by the attending physician or a diagnosis of a permanent unconscious state by 2 physicians and documented in the individual's health record.

## SYSTEMIC FAILURES

On 02/28/24, Sgt. Roberson met with Ms. Reyes to discuss her paperwork seeking assistance ptting a DNR in place. The exact thought process for Ms. Reyes is not detailed, but Sgt. Roberson does make inquiries about if she has plans to hurt herself. Ms. Reyes reports she didn't, but Sgt. Robertson does submit a 13-420 Mental Health referral for Ms. Reyes and notifies both records and her provider Simone asking about how she would go about getting her identification badge changed to reflect she is DNR.

On 03/06/24, an entry in Ms. Reyes record states, "A new badge will be issued to this individual, with "Do Not Resuscitate" listed on the identification. Health services contacted records and provided the following statement: "This I/I has specified with me that she wants to have a "DNR" status done due to her religious beliefs. We discussed the various levels of care short CPR, and her choices are documented in her medical record, along with her decision to, in advance, decline CPR. She specifically requested to have this on her badge and supporting documentation is in place. If you can make this happen for her, I would be very appreciative. Thank you, Kristin Simone ANRP, FNP-BC".

On 03/06/24, Sgt. Robinson documented the following in Ms. Reyes records: "Writing this chrono on I/I Reyes on an incident in CCU with Sgt. Knowles. On 03/03/24, at approximately 2100 hours, I/I Reyes, Danielle 371025 came to the CCU Sargeant's office and asked to speak with me. She showed me a medical form which I do not remember the exact wording, but bottom line it is a DNR. She stated that she needs a new ID, so it displays this. I assisted her with filing out a new ID request. She gave me the DOC form number stating that it shows she doesn't have to pay for it because of the reasoning. I asked her if there was something she wanted to talk to me about if she was ok. She said she was ok and no there wasn't. I did tell her I was concerned that she is so young and has a DNR in place. I asked if there was a reason for that. She stated that she tried to take her life previously and CO Norman found her the last time. She stated that she didn't want to come back and having this in place would prevent that. She also stated that if we were to attempt to help her that we would get into trouble. I again voiced my concern regarding the issue and advised her to reach out to me or anyone if she needed to. I/I was given her new DOC ID today by myself and Sgt. Knowles."

For Ms. Reyes multiple divisions within the agency failed to recognize that she was ineligible for a DNR, still provided her one, and provided her documentation on her DOC Identification.

> *The staff involved in the issuance of this DNR span the Women's Prisons Division, Health Services, and the Records Department.*

It should be noted that having a current DNR, likely would not have impeded Ms. Reyes being saved at the time she was discovered. Multiple staff reported that Ms. Reyes was obviously dead at response, to include one staff being very frank that she was cold and dead. Leaving again questions about the quality of checks being completed by staff, and the thoroughness of investigations that should be asking and answering the question of whether it was physiologically possible for physical circumstances to meet staff statements.

If none of the investigating staff could form that question after receiving statements that a person was cold and dead, then the question of a systemic failure on the qualification of the investigators comes into questions. According to the Journal of Forensic Science, Medicine, and Pathology:

The time it takes for a deceased person's body to cool to ambient temperature, a process known as algor mortis, varies based on several factors, including environmental conditions, clothing, body composition, and the initial body temperature at the time of death.

Under typical conditions, the body temperature decreases approximately 1.5°F (0.8°C) per hour during the first 12 hours post-mortem. After this period, the rate of cooling may slow as the body approaches the ambient temperature.

GENERAL TIMELINE:

**Initial Cooling:**

After death, the body begins to lose heat at a rate of about 1.5°F (0.8°C) per hour under normal room temperature (around 70–75°F or 21–24°C).

In cooler environments, the rate of cooling may be faster; in warmer conditions, it may be slower.

**Reaching Ambient Temperature:**

Typically, it takes 12 to 24 hours for the body to cool to the surrounding temperature, depending on the environmental conditions and the insulation provided by clothing or coverings.

**Influencing Factors:**

Ambient Temperature: A body cools faster in a cold environment and slower in a warm one.

Body Size and Composition: Larger or more insulated bodies (e.g., those with more fat) retain heat longer.

Clothing: Layers of clothing can slow heat loss.

Surface Contact: Contact with cold surfaces (e.g., the ground or metal) can accelerate cooling.

Exact timelines can be influenced by these variables, and professionals often combine algor mortis with other post-mortem signs (like rigor mortis and livor mortis) to estimate the time of death.

**Questioning the Systemic Possibility:**

In the chain of responsibility for the training, completion, and quality of Critical Incident Reviews is the Senior Administrator for Correctional Operations, Lorne Spooner. Mr. Spooner actively engages in the CIR review process. While other Department staff may be unaware of forensic tenants and investigative questions, Mr. Spooner previously served as both a city police officer and a county sheriff prior to his employment with the Department. Mr. Spooner is on record having been present for violent crimes, deceased individuals, and previously served active combat tours in the United States Miliary in the Middle East. It seems highly unlikely that cold and dead would escape his professional scrutiny and not provoke questions to ascertain if this was in fact the case.

Ms. Reyes death was also responded to by Detectives with the Washington State Patrol. No mention of their report number, findings or investigatory notes is provided in the Critical Incident Review report for Ms. Reyes.

## DELIBERATE INDIFFERENCE

In Washington State, the standard for "deliberate indifference" varies depending on the legal context, particularly between federal and state constitutional claims.

Federal Standard: Under the Eighth Amendment of the U.S. Constitution, which prohibits cruel and unusual punishment, "deliberate indifference" involves a two-pronged test:

**Objective Component:** The deprivation must be "sufficiently serious," posing a substantial risk of serious harm.

**Subjective Component**: The official must have actual knowledge of the risk and disregarded it by failing to take reasonable measures to mitigate it.

This standard was articulated by the U.S. Supreme Court in Farmer v. Brennan, 511 U.S. 825 (1994).

### WASHINGTON STATE

Washington State Constitution's Article I, Section 14, which addresses cruel punishment, has been interpreted to offer broader protections than the federal Eighth Amendment. In re Williams, the Washington Supreme Court recognized that the state constitution provides greater safeguards regarding conditions of confinement. The court established a test that considers:

**Significant Risk of Serious Harm**: Whether the conditions expose the individual to a substantial risk of serious harm.

**Legitimate Penological Interest:** Whether the conditions are reasonably related to a legitimate penological objective.

This approach emphasizes the necessity of humane treatment and the state's obligation to ensure that confinement conditions do not inflict unnecessary suffering.

# CURRENT SYSTEM FAILURES

## THE QUESTION SHOULD BE ASKED AND INVESTIGATED BY AN OUTSIDE BODY SUCH AS THE DEPARTMENT OF JUSTICE'S OFFICE OF CIVIL RIGHTS

**Did Secretary Strange and Deputy Secretary Murphy's failures as the leaders and organization governance of the Washington State Department of Corrections (DOC) directly lead to systemic failures where the lack of proper training and supervision of employees resulted in "deliberate indifference" to safeguarding the rights incarcerated individuals?**

These are just five individual who died during a six-month time frame during 2024. They do not encompass all individuals that died in custody during this time. It is known that processes were not followed by department administrators to ensure policies covering the death of individuals were complied with. At the core of correctional practices, preservation of safe and humane environments is tantamount, and here there is clearly systemic breakdowns occurring.

If maintain the lives of those in custody is failing, it begs the question to what extent are less priority processes failing as well? When Washington courts apply the "deliberate indifference" standard, this requires showing that the governmental entity was aware of the need for more or different training and made a deliberate choice to not provide it, leading to a violation of constitutional rights. The Washington Pattern Jury Instructions outline this standard, emphasizing the need for proof of a conscious or reckless disregard of the consequences.

While Washington State aligns with the federal "deliberate indifference" standard in certain contexts, our State Constitution provides enhanced protections, particularly concerning conditions of confinement, reflecting a commitment to more stringent safeguards against inhumane treatment.

### REQUIRED ELEMENTS FOR PROOF

To establish "deliberate indifference" for failure-to-train claims, plaintiffs must prove:

**Notice of a Pattern:** The government entity knew or should have known of a pattern of constitutional violations. (e.g., multiple complaints or lawsuits).

**Conscious Disregard:** Despite this knowledge, the entity deliberately chose not to act (e.g., by failing to implement training programs).

**Causation:** The lack of training directly caused the specific violation or harm.

### WORKING EXAMPLES

**Improper Use of Restraints:** A correctional facility fails to train officers on the proper use of restraints, such as handcuffs or shackles, leading to injuries or excessive pain for individuals. For example, officers may tighten handcuffs to the point of cutting off circulation because they were never trained on safe application.

**Chemical Agents:** Officers are not trained on the safe use of pepper spray or tear gas, despite its regular use in the facility. This lack of training results in excessive exposure or inappropriate deployment in confined spaces, causing severe injuries or deaths.

**Failure to Monitor Vulnerable Individuals:** Staff are not trained on protocols for monitoring high-risk individuals, such as those in protective custody or with known threats against them. As a result, an individual is assaulted or killed by others in the general population.

**Failure to Intervene in Fights:** Officers are not trained on de-escalation techniques or proper protocols for breaking up individual altercations. This results in delayed responses to individual fights, leading to serious injuries or deaths.

**Failure to Identify Mental Health Needs:** Staff are not trained to recognize signs of mental illness or distress. An individual showing clear signs of suicidal ideation is ignored or mishandled, resulting in self-harm or suicide.

**Suicide Watch Protocols:** Despite prior incidents of suicide, officers are not trained on proper procedures for suicide watch, such as regular checks or removing items individuals could use to harm themselves. An individual in custody dies by suicide due to these failures.

**Delayed or Denied Medical Care:** Staff are not trained to recognize medical emergencies, such as symptoms of a heart attack, stroke, or shock. This results in an individual not receiving care until it is too late.

**Medication Administration:** Employees are not trained on how to handle or administer prescribed medications. Errors in dosage or outright denial of medication lead to serious health complications for individuals.

**Infectious Disease Outbreaks:** Corrections staff are not trained to manage infectious disease protocols, such as isolating infected individuals or ensuring proper hygiene. This failure leads to outbreaks of diseases like tuberculosis or COVID-19.

**Handling Disabled Individuals:** Staff are not trained on how to accommodate individuals with physical or cognitive disabilities, such as those needing assistance with mobility or communication. This results in neglect or harm to these individuals.

**Use of Solitary Confinement:** Officers are not trained on the psychological effects of solitary confinement and inappropriately place mentally ill individuals in isolation without consideration of its adverse impact.

**Fire Safety and Evacuations:** Staff are not trained on fire safety procedures or how to evacuate individuals during emergencies. In the event of a fire, chaos ensues, leading to preventable injuries or fatalities.

**Natural Disaster Preparedness:** Corrections staff are not trained on disaster response protocols, such as handling floods, earthquakes, or hurricanes. A failure to act swiftly leads to harm to individuals during a natural disaster.

**Failure to Train on Searches:** Officers are not trained on proper search techniques, leading to contraband, such as weapons or drugs, entering the facility. This oversight contributes to individual violence or overdoses.

**Overly Intrusive Searches:** Staff are not trained on legal boundaries for searches, resulting in invasive or humiliating body searches that violate individuals' constitutional rights.

**Inadequate Training in Individual Transport:** Staff are not trained on securing individuals safely during transport. This results in injuries during a vehicle accident or escape attempts due to improper restraints.

**Bias in Decision-Making:** Staff are not trained on avoiding racial, gender, or religious bias in treatment of individuals. This results in discriminatory practices that lead to unequal access to privileges, healthcare, or safety.

**Failure to Train on De-Escalation:** Officers escalate minor disputes into violent confrontations because they lack training in conflict resolution or communication skills.

> *Each of these scenarios highlights how failure to train corrections staff can lead to serious harm, implicating constitutional rights under the Eighth or Fourteenth Amendments.*

**Establishing "deliberate indifference" in such cases would require showing a pattern of prior incidents or obvious risks that the administration ignored.**

# CONCLUSION

## LOOKING FORWARD WITH AN EYE TO THE PAST

The Washington State Department of Corrections (DOC) early release scandal emerged in December 2015 when it was revealed that a software error had caused the premature release of approximately 3,200 prisoners over a 13-year period. This error, originating from a miscalculation of good behavior credits, was first identified in 2002 but was not corrected despite being reported internally.

- DOC's software incorrectly calculated sentences, leading to incarcerated individuals being released early based on inflated good behavior credits. The issue primarily affected incarcerated individuals with enhanced sentences or special sentencing structures.
- The error was discovered in 2012 when a family member of a victim flagged the issue.
- Despite being aware of the problem, the DOC delayed fixing the software due to competing priorities, pushing the timeline back repeatedly.
- The early releases involved individuals convicted of a variety of offenses, including serious crimes. Some individuals who were released early committed additional crimes, including a fatal vehicular crash in 2015.
- Public Outcry and Accountability. The scandal led to significant public backlash against the DOC and state leadership.
- Governor Jay Inslee ordered an independent investigation and instituted emergency measures to manually verify release dates while the software was fixed.
- The independent investigation found systemic failures, including a lack of urgency and inadequate oversight within the DOC.
- Governor Inslee took corrective action, including terminating key officials involved in the oversight of the issue.
- Reforms were implemented to improve accountability, including new policies for addressing identified errors and improving IT system checks.
- The scandal underscored systemic issues within the Washington State DOC and highlighted the need for greater diligence in ensuring public safety and institutional accountability.

### PARTNERING FOR SOLUTIONS

Our alliance of employees, families, community, advocacy and supervised/incarcerated individual feels confident that these systemic failures have again arisen in the aftermath of Covid. There are real problems that many people can see, but we are over and over dismissed at all levels of the agency. We have operating divisions required to operate in silos, as the Strange/Murphy Administration continually manages the department without collaborative teams, gatekeeps collaboration with the larger community, and provides relatively little transparency. An exterior example being family advocates being subjectively treated to a high user protocol. Allowing the Department to exempt themselves from responding by arbitrarily deciding a person is a "high user". No criteria, no notification, no appeal – no due process. This pits each respective group against each other, and as the past has shown it leaves those dedicated to this work vulnerable to taking the fall when the inevitable tragedy occurs, and the winds of political accountability come.

Employees, families, supervised/incarcerated people, advocates, and community also feel no real avenue to bring the systemic nature of this forward without the same systemic dismissal of concerns and retaliation occurring that has so routinely been faced by those who have spoken out in the past and present.

Alongside the Attorney General's Office and the Governor's Office, the Office of Corrections Ombudsman also has direct awareness throughout this chain of events. Concerns should be noted that we fear their ability to be objective at present as required in their role. We ask you to please consider our concerns about the state of DOC as illustrated by the five deaths above and our systemic concerns. As our elected leaders we look to you as we step forth into the State's next era for assistance in truly implementing the Mission, Vision and Values of the Department of Corrections (DOC).